

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 10				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 118 Sunset Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth Roe ABBOTT				4. DATE OF DEATH Month Day Year May 31 19 62							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 21, 1898		9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY Home				11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Medford Roe				14. MOTHER'S MAIDEN NAME Amanda Thompson							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT J. Vernon Abbott Address (2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 092X DUE TO Acute massive hepatic necrosis Conditions, if any, which gave rise to immediate cause (b) Acute viral hepatitis type A (c) 5 days DUE TO 5 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH 3 days 5 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) did not attended the deceased from 4/27 , 19 62 to May 31 , 19 62 that (I) did not saw the deceased alive on May 31 , 19 62 , and that death occurred at 5:30 PM from the causes and on the date stated above.											
22a. SIGNATURE General Blunt				M.D. GOVERNOR CHURCH		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/1/62			
22c. PHYSICIAN'S NAME (Type) GOVERNOR CHURCH				22d. ADDRESS 121 CATHERINE ST ANNAPOLIS MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-3-62		23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff				23d. LOCATION (City, town or county) (State) Annapolis Md			
24. FUNERAL DIRECTOR'S SIGNATURE John W. Taylor Sons						ADDRESS Annapolis Md		25a. REC'D BY REGISTRAR DATE JUN 4 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Huang	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
05323										
05318										
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>			c. LENGTH OF STAY IN 1b <u>1 1/2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>			d. STREET ADDRESS <u>302 E. Pasadena Rd.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>302 E. Pasadena Road</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Evalyn</u> Middle <u>F.</u> Last <u>Acree</u>					4. DATE OF DEATH Month <u>MAY</u> Day <u>18</u> Year <u>1962</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>31 Dec. 1881</u>		9. AGE (In years last birthday) <u>80</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		
13. FATHER'S NAME <u>Thornton Longest</u>					14. MOTHER'S MAIDEN NAME <u>Georgia Broach</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Name <u>Mrs. Sarah Lewis</u> Address <u>Same As #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRO-VASCULAR ACCIDENT</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>CEREBRAL ATHEROSCLEROSIS</u> (e), stating the underlying cause last. DUE TO (c) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u> <u>2 YRS.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u> </u>						
20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u>		20g. (County) <u> </u>		
20h. (State) <u> </u>		21. I certify that (I) (this hospital) attended the deceased from <u>AUGUST 5-14, 1962</u> to <u>MAY 23, 1962</u> , that (I) (we) last saw the deceased alive on <u>5-14-1962</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.								
22a. SIGNATURE <u>Leon C. Perry</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5-18-62</u>			
22c. PHYSICIAN'S NAME (Type) <u>LEON C. PERRY, M.D.</u>					22d. ADDRESS <u>201 BRADBURY, GLEN BURNIE, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL? (Specify) <u>Burial</u>		23b. DATE THEREOF <u>21st May 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>		23d. LOCATION (City, town or county) <u>Glen Burnie</u>		23e. (State) <u>Maryland</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>K. V. Singleton</u>					ADDRESS <u>Glen Burnie, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 22 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

05324

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05319

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL - Edgewater			
d. STREET ADDRESS 1				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Peter Middle P Last ALSQUITH Sr				4. DATE OF DEATH Month May Day 14 Year 1962			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-30-1878	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 83 Days 83 Hours 83 Min.		IF UNDER 24 HRS. Months 83 Days 83 Hours 83 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY TOBACCO FARMER		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME GEORGE ASQUITH				14. MOTHER'S MAIDEN NAME MARY IRELAND			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —				16. SOCIAL SECURITY NO. —			
17. INFORMANT ETHEL PHIPPS				Address FARMGUT RD. ANNAPOLIS MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 42011 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of pancreas INTERVAL BETWEEN ONSET AND DEATH sudden							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) who is present attended the deceased from May 12 , 19 62 , to May 14 , 19 62 , that (I) XX last saw the deceased alive on May 14 , 19 62 , and that death occurred at 1:10 PM , from the causes and on the date stated above.							
22a. SIGNATURE Jesse L. Wilkins				22b. DATE 5/14/62			
22c. PHYSICIAN'S NAME (Type) Jesse L. Wilkins, M.D.				22d. ADDRESS 98 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 5-17-62		23c. NAME OF CEMETERY OR CREMATORY Ahh Hahhows		23d. LOCATION (City, town or county) (State) Birosovich Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons Annapolis, Md.				25a. REC'D BY REGISTRAR DATE MAY 16 '62			
25b. REGISTRAR'S SIGNATURE Arthur L. Hines							

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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05320

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Knollwood Manor, Millersville, Md.</u>				e. STREET ADDRESS <u>209 Greenland Beach Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>WILLIAM M. ALBIKER</u>				4. DATE OF DEATH <u>May 30 1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 2, 1890</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Albiker</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-05-6070</u>		17. INFORMANT <u>Mrs. Juanita Walker, 209 Greenland Beach Rd.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> DUE TO (b) <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>6 days</u> DUE TO (c) <u>6 days</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral disease</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>chronic bronchitis and emphysema</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/25 12:05</u> to <u>5/30</u> , 1962, that (I) (we) last saw the deceased alive on <u>5/29</u> , 1962, and that death occurred at <u>7</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>General Church</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>CONRAD CHURCH</u>	
22d. ADDRESS <u>121 CATHERINE ST ANNAPOLIS</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 2, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Ritchie Hwy, A. A. Co. Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>FLYNN & FLEMING, INC.</u>				25a. REC'D BY REGISTRAR <u>FLYNN</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kerner</u>	

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[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "RECEIVED" and "1953" are visible.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05321
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. LENGTH OF STAY IN 1b <u>-</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Severn River near Old Severn River Bridge</u>					1d. STREET ADDRESS <u>APL, U.S. Naval Academy</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Francisco</u> Middle <u>Alejo</u> Last <u>ALCAFARAS</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>19</u> Year <u>19 62</u>							
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Malayan</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>26 July 1942</u>		9. AGE (In years last birthday) <u>19</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TH STEWARD</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>USN</u>		11. BIRTHPLACE (State or foreign country) <u>Philippines</u>		12. CITIZEN OF WHAT COUNTRY? <u>Philippines</u>			
13. FATHER'S NAME <u>Gabriel Alcaferas</u>					14. MOTHER'S MAIDEN NAME <u>Leonie A. Alejo</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>			16. SOCIAL SECURITY NO. <u>9/16/60 to</u>		17. INFORMANT <u>ICDR L.C. DENEY USN</u> Address <u>U.S. Naval Station Annapolis, Maryland</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>850x DUE TO Drowning</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>* Knocked in the water while attempting to raise the sail of a boat he was sailing alone.</u>							
20c. TIME OF INJURY Hour <u>11</u> P.M. Month, Day, Year <u>19 May 1962</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Severn River</u>		20f. (City or town) <u>Annapolis, Anne Arundel, Md.</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>										
ACTUAL SIGNATURE <u>E. Linbrook</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED <u>5/29/62</u>
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>			22b. DATE THEREOF <u> </u>		22c. NAME OF CEMETERY OR CREMATORY <u>Naval Shipyard</u>		22d. LOCATION (City, town, or county) (State) <u>50-Full St. San Francisco California</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Earl B. Wightman</u> <u>6306 - Belair Rd. Baltimore - 6, Md</u>					24a. REC'D BY REGISTRAR DATE <u>MAY 23 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

* Newspaper

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Age: _____

3. Sex: _____

4. Race: _____

5. Date of Death: _____

6. Place of Death: _____

7. Cause of Death: _____

8. Manner of Death: _____

9. Signature of Examiner: _____

10. Signature of Coroner: _____

11. Signature of Physician: _____

12. Signature of Medical Examiner: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 & 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05327

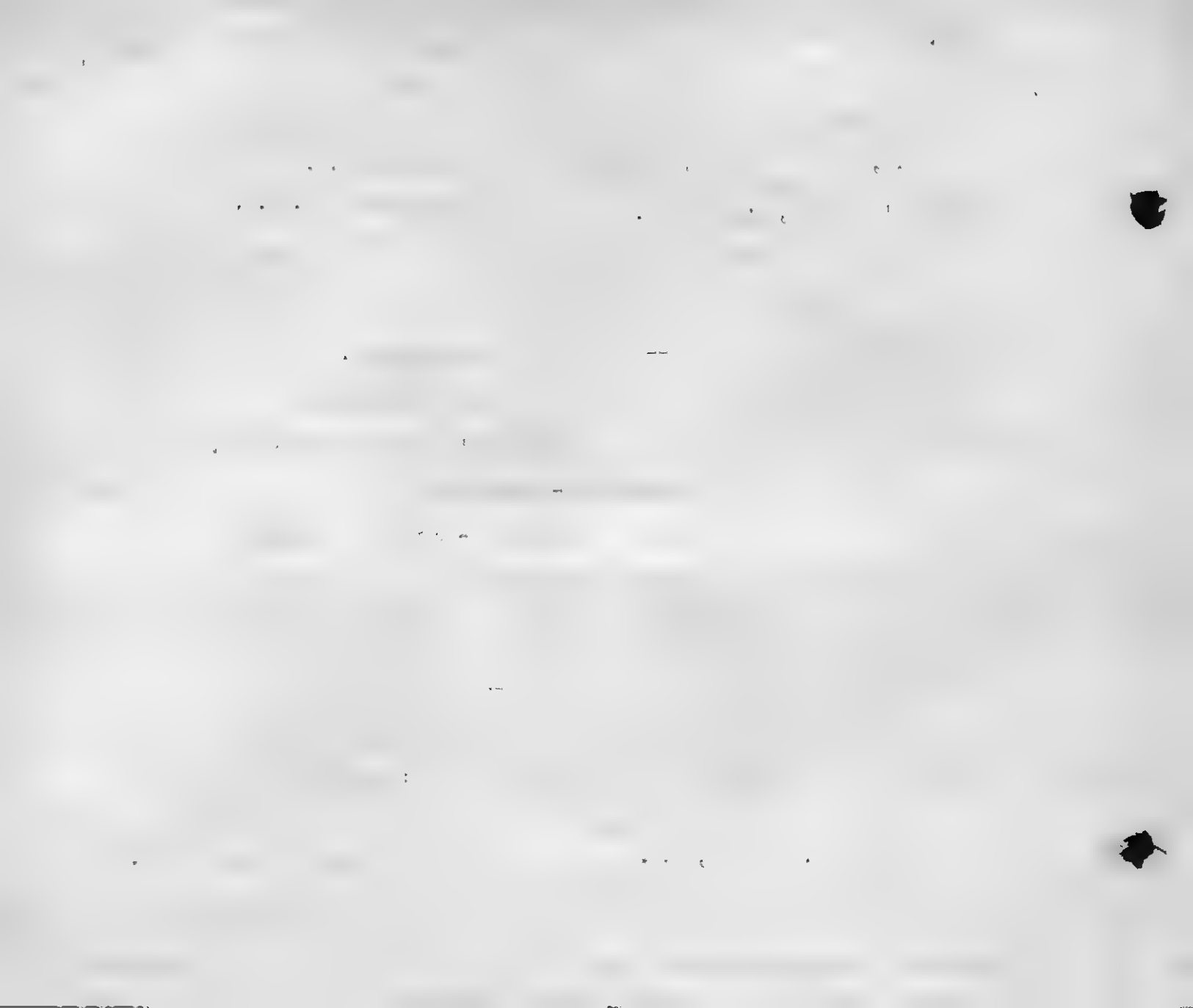
05322

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN b 3 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL - Edgewater d. STREET ADDRESS Salisbury & Woodland Beach, Dr. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cecil Middle W Last AYLOR		4. DATE OF DEATH Month May Day 27 Year 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 11, 1911	
9. AGE (In years last birthday) 50		10. IF UNDER 1 YEAR Months 50	
11. IF UNDER 24 HRS. Days 50		Hours 50	
12. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi Driver		10b. KIND OF BUSINESS OR INDUSTRY Taxi Driver	
11. BIRTHPLACE, County & State, or foreign country Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John L. Aylor		14. MOTHER'S MAIDEN NAME Bessie Whispell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. Mary E. Aylor	
17. INFORMANT Mary E. Aylor		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage, h. thrombosis 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) General & cerebral arteriosclerosis (a), stating the underlying cause last, DUE TO (c) ?	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) physician attended the deceased from 5/24/62 to May 27, 1962 that (I) did not see the deceased alive on May 26, 1962 , and that death occurred at 1:30 AM , from the causes and on the date stated above.			
21a. SIGNATURE Maurice Klawans M.D.		21b. DATE 5/28/62	
22c. PHYSICIAN'S NAME (Type) Maurice Klawans		22d. ADDRESS 31 Southgate Ave., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL? (Specify) Burial		23b. DATE THEREOF 5-29-62	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town or county) Washington (State) B.C.	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor		25a. REC'D BY REGISTRAR DATE MAY 29 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL, MD c. LENGTH OF STAY IN 1b 7 years d. NAME OF HOSPITAL AND/OR INSTITUTION (If in hospital, give street address) DISTRICT TRAINING SCHOOL CHILDREN'S CENTER, LAUREL, MD.						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE WASHINGTON, D.C. b. COUNTY 47X 2 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1318 HOLBROOK ST. N.E. d. STREET ADDRESS 1318 HOLBROOK ST. N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) LAWRENCE LEE BALL			4. DATE OF DEATH Month MAY Day 16 Year 1962			5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 3/20/53 9. AGE (In years last birthday) 9 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSTITUTIONALIZED			10b. KIND OF BUSINESS OR INDUSTRY ---			11. BIRTHPLACE (County & State, or foreign country) WASHINGTON D.C.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME THEODORE ALBERT BALL						14. MOTHER'S MAIDEN NAME JUNE REBECCA SHARP					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ** ** (If yes give war or dates of service) ** **			16. SOCIAL SECURITY NO. ** **			17. INFORMANT CHILDREN'S CENTER, LAUREL, MD.			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration - pneumonia 225.5 DUE TO Conditions, if any, which gave rise to immediate cause (b) Mental retardation - cerebral agenesis (a), stating the underlying cause last. DUE TO (c) Convulsive disorder									INTERVAL BETWEEN ONSET AND DEATH 3 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 5/13/55 19....., to 5/16/62 19....., that (I) (we) last saw the deceased alive on 5/16/62 19....., and that death occurred at 3:00pm from the causes and on the date stated above.											
22a. SIGNATURE James E. Boyland						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 5/16/62		
22c. PHYSICIAN'S NAME (Type) James E. Boyland, M.D.						22d. ADDRESS CHILDREN'S CENTER, LAUREL, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5/19/62			23c. NAME OF CEMETERY OR CREMATORY Forest Lawn MEM. PARK CYPRESS CALIFORNIA			23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR'S SIGNATURE Shirley J. Malden						ADDRESS Laurel			25a. REC'D BY REGISTRAR MAY 22 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Hume		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05329

05324

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOHIS</u> c. LENGTH OF STAY in lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>418 JEFFERSON ST.</u>												2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A. A. Co.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOHIS</u> d. STREET ADDRESS <u>418 JEFFERSON ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																															
3. NAME OF DECEASED (Type or print) <u>FLORENCE J. BARRY</u>												4. DATE OF DEATH Month <u>5</u> Day <u>26</u> Year <u>1962</u>																																															
5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>12-27-1901</u>												9. AGE (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>																																															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>												10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>												11. BIRTHPLACE (County & State, or foreign country) <u>ANNAPOHIS MD.</u>												12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>																							
13. FATHER'S NAME <u>JAMES M. CASEY</u>												14. MOTHER'S MAIDEN NAME <u>JEANETTE CLARK</u>												15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u> </u>												16. SOCIAL SECURITY NO. <u> </u>												17. INFORMANT <u>IRA J. BARRY</u> Address <u>#2</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Blood - Meinslated</u>																								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																			
20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>												20c. TIME OF INJURY Month, Day, Year <u> </u> Hour a.m. <u> </u> p.m. <u> </u>												20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>												20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>												20f. (City or town) (County) (State) <u> </u>											
21. I certify that (I) (this hospital) attended the deceased from <u>June 1960</u> to <u>5/26</u> that (I) (we) last saw the deceased alive on <u>5-26</u> 1962 and that death occurred <u>12:40 AM</u> from the causes and on the date stated above.																																																											
22a. SIGNATURE <u>E. L. Harkett</u>												22b. DATE SIGNED <u>5/26/62</u>												22c. PHYSICIAN'S NAME (Type) <u>E. L. Harkett</u>												22d. ADDRESS <u>Annapolis Maryland</u>																							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>												23b. DATE THEREOF <u>5-30-62</u>												23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>												23d. LOCATION (City, town or county) (State) <u>ANNAPOHIS MD.</u>																							
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>												25a. REC'D BY REGISTRAR <u> </u>												25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>												DATE <u>MAY 29 '62</u>																							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05330

CERTIFICATE OF DEATH

05325

Item 1 Film G312 7/8/62 iwk

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN b. <u>30 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>His residence-</u> NAME OF DECEASED (Type or print) <u>Joseph Vernon Becker</u> 5 SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 19, 1900</u> 9. AGE (In years last birthday) <u>62</u> yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter II</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Crownsville State Hospital</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> 13. FATHER'S NAME <u>Otto Becker</u> 14. MOTHER'S MAIDEN NAME <u>Annie M. Hepting</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>220-36-6919</u> 17. INFORMANT <u>Bertha M. Becker</u> <u>Wife and Employment Records</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cachexia</u> 199 X DUE TO <u>Generalized Carcinosis (Primary Site Undisclosed)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Office</u> 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <u>April 20, 1962</u> to <u>May 1, 1962</u> , that (I) (we) last saw the deceased alive on <u>May 1, 1962</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above 22a. SIGNATURE <u>L. Benedict, M. D.</u> 22b. DATE SIGNED <u>5/1/62</u> 22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u> 22d. ADDRESS <u>Crownsville State Hospital, Maryland</u> 23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>5-4-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u> 23d. LOCATION (City, town or county) (State) <u>Glen Burnie Md</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Glen M. Taylor Sons</u> ADDRESS <u>Annapolis Md</u> 25a. REC'D BY REGISTRAR DATE <u>MAY 3 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL CERTIFICATION										
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND										
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville					c. LENGTH OF STAY IN 1b 1 mo. 14 days					
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston					d. STREET ADDRESS Box 83					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) 3-#22051 First John Middle Wesley Last Boyce										
4. DATE OF DEATH Month 5 Day 6 Year 19 62										
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 15, 1897		9. AGE (In years last birthday) 64 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		IF UNDER 1 YEAR Months Days Hours Min.		
13. FATHER'S NAME Donald Boyce					14. MOTHER'S MAIDEN NAME Laura					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-18-5840		17. INFORMANT Hospital Records Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia Due to Food Particles 921.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH Minutes										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome Associated with Generalized Arteriosclerosis										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Suddenly after supper he ceased breathing								
20c. TIME OF INJURY Month, Day, Year 6:30 5 6 62 Hour 6:30 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Crownsville State Hospital		20f. (City or town) Crownsville		20g. (County) A. A.		
20h. (State) Md.										
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE Elmer G. Linhardt					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Elmer G. Linhardt, M. D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 5-12-62		22c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		22d. LOCATION (City, town, or county) (State) Preston Md	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Hampton					ADDRESS Federalsburg, Md		24a. REC'D BY REGISTRAR DATE MAY 14 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Thoma	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7.61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05332 **05327**

1. PLACE OF DEATH
a. COUNTY U. A. Co. **MARYLAND**
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellenburnee
c. LENGTH OF STAY IN b. 2 Weeks
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 608 Everett Rd

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE md. b. COUNTY A. A. Co.
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellenburnee
d. STREET ADDRESS 608 Everett Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First Kurt Middle Brieger Last

4. DATE OF DEATH Month May Day 21 Year 1962

5. SEX Male **6. COLOR OR RACE** W. **7. MARRIED** ☒ **NEVER MARRIED** ☐ **8. DATE OF BIRTH** Jan. 29/03 **9. AGE** (In years last birthday) 59 yrs. **IF UNDER 1 YEAR** Months Days **IF UNDER 24 HRS.** Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ellenburnee **10b. KIND OF BUSINESS OR INDUSTRY** Reland Dr. appts. **11. BIRTHPLACE** (County & State, or foreign country) Germany **12. CITIZEN OF WHAT COUNTRY?** U S A

13. FATHER'S NAME Julius Brieger **14. MOTHER'S MAIDEN NAME** Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) 2/20/09-03/78 **16. SOCIAL SECURITY NO.** 212-09-0378 **17. INFORMANT** Lina Brieger (Same) Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 156.1 DUE TO CANCER of the Liver
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐ INTERVAL BETWEEN ONSET AND DEATH Weeks

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year May 19 1961
Hour a.m. o.m. 19
20d. INJURY OCCURRED While ☐ Not While ☐
at work ☐ at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at home
20f. (City or town) (County) (State) May 21 1962

21. I certify that (I) (this hospital) attended the deceased from May 18 1962 **and that death occurred at** May 21 1962 **from the causes and on the date stated above.**

22a. SIGNATURE Henry Armanas **22b. DATE SIGNED** May 21 1962
22c. PHYSICIAN'S NAME (Type) HENRY ARMANAS **22d. ADDRESS** 1934 Wilkens Ave. Baltimore 23, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial **23b. DATE THEREOF** 5/24/62 **23c. NAME OF CEMETERY OR CREMATORY** Edmondson **23d. LOCATION** (City, town or county) (State) Balto. 29, Md.

24. FUNERAL DIRECTOR'S SIGNATURE Witke 10.4101 Edmondson **25a. REC'D BY REGISTRAR** Arthur S. Huns **25b. REGISTRAR'S SIGNATURE** Arthur S. Huns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 36 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 31 Parole Street		d. STREET ADDRESS 31 Parole Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY First ANN Middle BROWN Last		4. DATE OF DEATH Month May Day 27 Year 19 62	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 24-1874
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 8 Days 27 Hours 19 Min. 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (State or foreign country) A.A.Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nathan Warren		14. MOTHER'S MAIDEN NAME Louise Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Louvenia Embry-42 Parole St. Anna. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-11-62 19 62 , to 5-27-62 19 62 , that I last saw the deceased alive on 5-27-62 19 62 , and that death occurred at 6 L Cathedral Street M.D. 5-27-62			
ACTUAL SIGNATURE A.T. Allen		DATE SIGNED 5-27-62	
PHYSICIAN'S NAME (Type) A.T. Allen		Cathedral Street-Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF May 30-62	
22c. NAME OF CEMETERY OR CREMATORY Fowlers		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C.E. HICKS		ADDRESS 111 Annapolis, Maryland	
24a. REC'D BY REGISTRAR DATE JUN 4 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Keene	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

05334

CERTIFICATE OF DEATH

05329

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>ANNE ARJUEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARJUEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) Maryland <u>Kimbrough Army Hospital Ft Geo. G. Meade</u>		d. STREET ADDRESS <u>Jacksongrove Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William S. Carter</u>		4. DATE OF DEATH Month Day Year <u>May 26 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19 1900</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired M. Sgt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N/A US Army</u>	
11. BIRTHPLACE (State or foreign country) <u>Ruffin North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Horace Carter</u>		14. MOTHER'S MAIDEN NAME <u>Lillie Price Chandler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>41-119-83160</u>	
17. INFORMANT <u>Mrs Wm S. Carter, Severn, Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Pulmonary Insufficiency</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>21 May</u> , 19 <u>62</u> , to <u>26 May</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>May 26</u> , 19 <u>62</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>US Army Hospital, Ft Meade, Md 26 May 62</u>			
ACTUAL SIGNATURE <u>William Goldstein, M.D.</u>		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<u>Burial</u>		<u>5/31/62</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Abington National</u>		<u>Abington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>William Goldstein</u>		<u>1111</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>JUN 4 '62</u>		<u>Arthur L. Hume</u>	

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Pages 1, 2, and 3 should be used as a burial-transit permit. File pages 4 and 5 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

05335 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05330

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>	
c. LENGTH OF STAY IN 1b <u>4 Y.</u>		d. STREET ADDRESS <u>Same</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1202 Wilson Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Amy E. Coppard Caughy</u>		4. DATE OF DEATH <u>May 7th.</u> 19 <u>62</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/5/75</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Eastbourne, England.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George W. Baker</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Castle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Informant</u>	
17. ADDRESS <u>Mrs. Marion Beavers, (daughter) 1202 Wilson Rd Glen Burnie</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>General Asthenia</u> <u>794X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c), stating the underlying cause last. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-9-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or country) <u>Glen Burnie, Md.</u> (State)	
23. FUNERAL DIRECTOR <u>John J. Jackson & Sons Baltimore, Md.</u>		24a. REC'D BY REGISTRAR <u>MAY 8 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		DATE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY in 1b 9 mos. 6 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1314 Fremont Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James W. Clement First Middle Last 3-#22674		4. DATE OF DEATH Month Day Year 5 31 19 62	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May, 1903
9. AGE (In years last birthday) 59 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Emal Clement	
14. MOTHER'S MAIDEN NAME Jenny		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 212-12-6421		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Uremia DUE TO (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year 19 Hour am p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----- 20f. (City or town) ----- (County) ----- (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 8/25 to 5/31 , 19 62 , that (I) (we) last saw the deceased alive on 5/31 , 19 62 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Lionel McHenry Mapp, M. D.		22b. DATE 5/31/62	
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 6-6-62	
23c. NAME OF CEMETERY OR CREMATORY 2107 Md.		23d. LOCATION (City, town or county) Balto. Md. (State) -----	
24. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr. - Annapolis, Md.		25a. REC'D BY REGISTRAR AUN 7 '62	
25b. REGISTRAR'S SIGNATURE Arthur J. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
05337 CERTIFICATE OF DEATH 05331										
Item 6 File G515 5/11/62 iwk										
1. PLACE OF DEATH a. COUNTY <u>Maryland</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>14 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>#1312 Howard Road (Harundale)</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> d. STREET ADDRESS <u>#1312 Howard Road (Harundale)</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>GILBERT F.B. COLWELL</u>		4. DATE OF DEATH <u>May 9 1962</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Proctor & Gamble</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Joseph B. Colwell</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Lent</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215 03 6263</u>		17. INFORMANT <u>Mrs. Dorothy F. Colwell</u> Address <u>Same As #2</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c) <u>420.1</u>										INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardio-Vascular Disease</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT, WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>See</u>		20f. (City or town) <u>53 May 62</u>		(County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>5-5-1962</u> to <u>May 9 1962</u> that (I) (we) last saw the deceased alive on <u>5-5-1962</u> and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.										
22a. SIGNATURE <u>Charles R. MacDonald M.D.</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5-11-62</u>			
22c. PHYSICIAN'S NAME (Type) <u>Charles R. MacDonald</u>					22d. ADDRESS <u>202 Crain Highway, S.W., Glen Burnie, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12th May 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>		23d. LOCATION (City, town or county) <u>Glen Burnie, Maryland</u>		(State)		
24. FUNERAL DIRECTOR'S SIGNATURE <u>R.V. Sington</u> ADDRESS <u>Glen Burnie, Md.</u>					25a. REC'D BY REGISTRAR <u>MAY 15 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05332
05332
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) PASADENA c. LENGTH OF STAY in lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Box 409-RITCHIE HIGHWAY		2. USUAL RESIDENCE (Where deceased lived, if institution; Res. since before admission) a. STATE MD. b. COUNTY A.A.C.O. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) PASADENA d. STREET ADDRESS Box 409-RITCHIE HWY. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARIE ELIZABETH COMBS First Middle Last 5. SEX F 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH JAN. 16, 1890 9. AGE (In years last birthday) 72 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH MAY 29 1962	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER 10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) MD. 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME THOMAS H. STODDARD		14. MOTHER'S MAIDEN NAME NELLIE T. HEAGERTY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown); (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Hawkins-Ritchie Hwy.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arterio sclerotic Cardiovascular Dis. (a), stating the underlying cause last, } DUE TO (c) 10 years			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus, hypertension, osteoarthritis knees			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 1961 , to present , 19 1962 , that (I) (we) last saw the deceased alive on 18 Apr. 1962 , and that death occurred at 1235 A.M., from the causes and on the date stated above.			
22a. SIGNATURE C. Earl Hill 22c. PHYSICIAN'S NAME (Type) C. EARL HILL		22b. DATE SIGNED 29 May 62 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 3708 Mountain Rd. Pasadena, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 6-1-62	
23c. NAME OF CEMETERY OR CREMATORY Cathedral Cmn.		23d. LOCATION (City, town or county) (State) Balto. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Foley Funeral Home - Catonsville, Md.		25a. REC'D BY REGISTRAR 5 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>15 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1622 Manor Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>226 N. Carey Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mamie</u> <u>COTTMAN</u> <u>May</u>		4. DATE OF DEATH Month Day Year <u>May</u> <u>19</u> <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1892</u>
9. AGE (in years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months Days <u>15</u> <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Hypertensive Cardiovascular Renal Disease</u> DUE TO (c) <u>Arteriosclerosis - Generalized</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Decubitus Ulcers - Old Cerebrovascular Accident</u>			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/9/1962</u> to <u>5/19/1962</u> ; that (I) (we) last saw the deceased alive on <u>5/19/1962</u> , and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Lionel M. Mapp</u>		22b. DATE SIGNED <u>May 22 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lionel M. Mapp</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 23 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Westport (Baltimore)</u> <u>MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joe L. Russ</u>		25. REC'D BY REGISTRAR <u>May 22 1962</u>	
ADDRESS <u>2222 N. T. Ave</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

13a 400-17

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

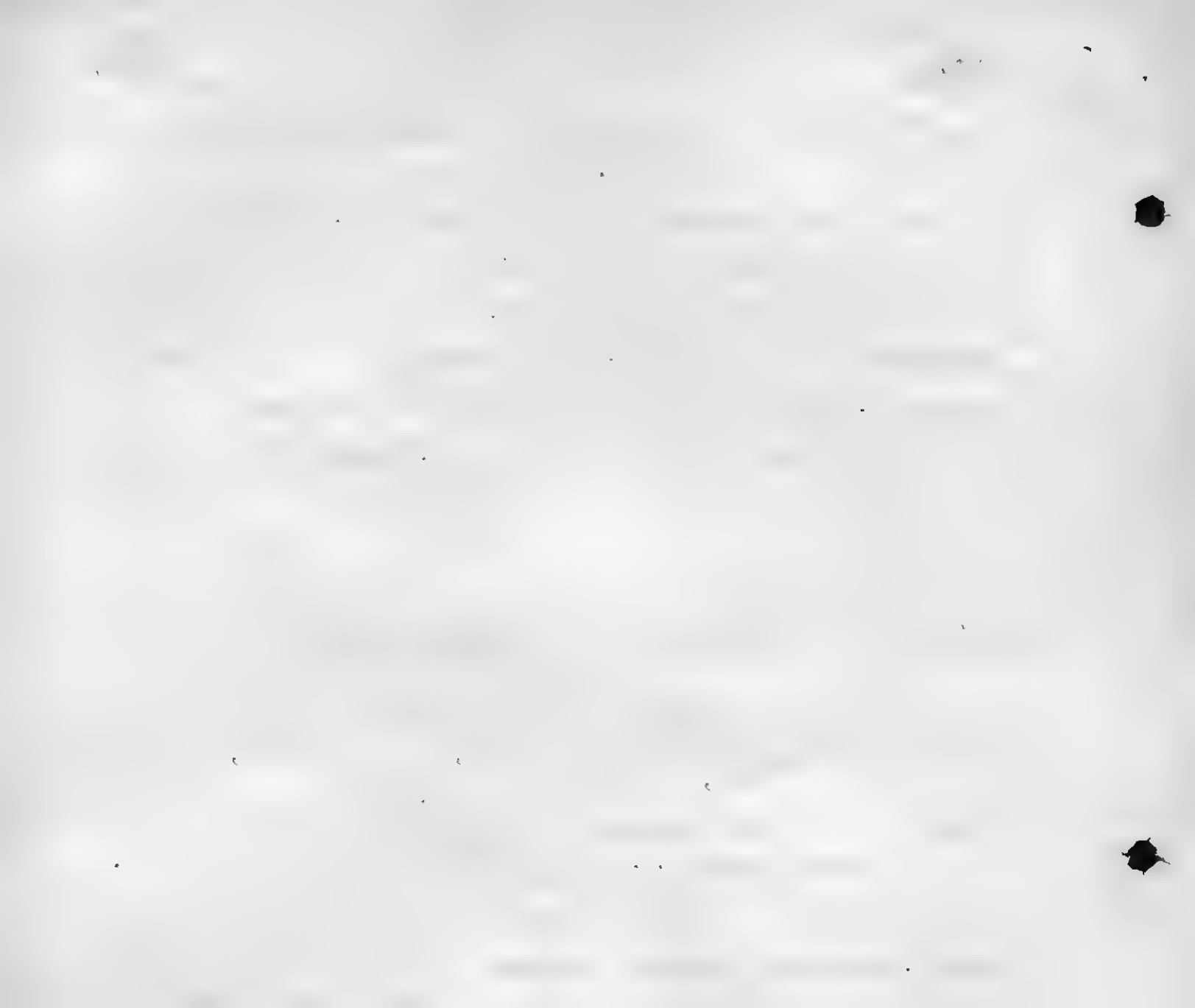
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05340

05334

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN IT 2 1/2 hrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riva d. STREET ADDRESS 12 Shore Walk, Silvern Shores	
3. NAME OF DECEASED (Type or print) Estelle O Dresser		4. DATE OF DEATH Month May Day 8 Year 1962	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 26, 1891	
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 24 HRS. Months 3 Days 12 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles W. Ogden		14. MOTHER'S MAIDEN NAME Virginia Robertson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Richard I. Dresser-Husband		18. ADDRESS same 2d	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Ac. Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). Diabetes mellitus; Chn. Nephritis		19. INTERVAL BETWEEN ONSET AND DEATH 4 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 e.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) James H. Klawans attended the deceased from May 7, 1962 to May 8, 1962 , that (I) James H. Klawans saw the deceased alive on May 8, 1962 , and that death occurred at 1:20 AM from the causes and on the date stated above.		22a. SIGNATURE James H. Klawans M.D.	
22b. PHYSICIAN'S NAME (Type) Maurice Klawans, M.D.		22c. ADDRESS 31 Southgate Ave., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/11/62	
23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		23d. LOCATION (City, town or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR May 14 '62	
25b. REGISTRAR'S SIGNATURE Charles E. Pumphrey		25c. DATE	



TO DEF. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05341

05335

1. PLACE OF DEATH a. COUNTY Anne Arundel Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Same		b. COUNTY Same	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, Md.		c. LENGTH OF STAY IN 1b 5 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 25, Md.		3VCI.4	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Smuck's Dump		d. STREET ADDRESS 2807 Carver Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Harold Harper Edwards		First Middle Last		4. DATE OF DEATH May 3 1962		Month Day Year	
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 10/9/33	
9. AGE (In years last birthday) 28 yrs.		10. UNDER 1 YEAR Months Days		11. UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Elkridge Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herbert Edwards		14. MOTHER'S M.A.DEN NAME Annebell Miles		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Pearl Edwards	
17. INFORMANT Same		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Crushed chest 812 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Jumped off of back of truck and fell under wheel. 20c. TIME OF INJURY Hour a.m. 11:00 Month, Day, Year May 3 1962 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Smuck's Dump 20f. (City or town) Glen Burnie (County) A.A.Co. (State) Maryland		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>Alvin Brown</i> Address (Street, city, town, or county) <i>Sm</i> DATE SIGNED May 3, 1962		22a. BURIAL, CREMATION REMOVAL (Specify) Burial 5/6/62 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY Mt Calvary Cemetary 22d. LOCATION (City, town, or country) Brooklyn Md.			
23. FUNERAL DIRECTOR Elroy O. Wilson 1000 Brantley Ave.		24a. REC'D BY REGISTRAR MAY 7 '62		24b. REGISTRAR'S SIGNATURE <i>Charles L. Thomas</i>			

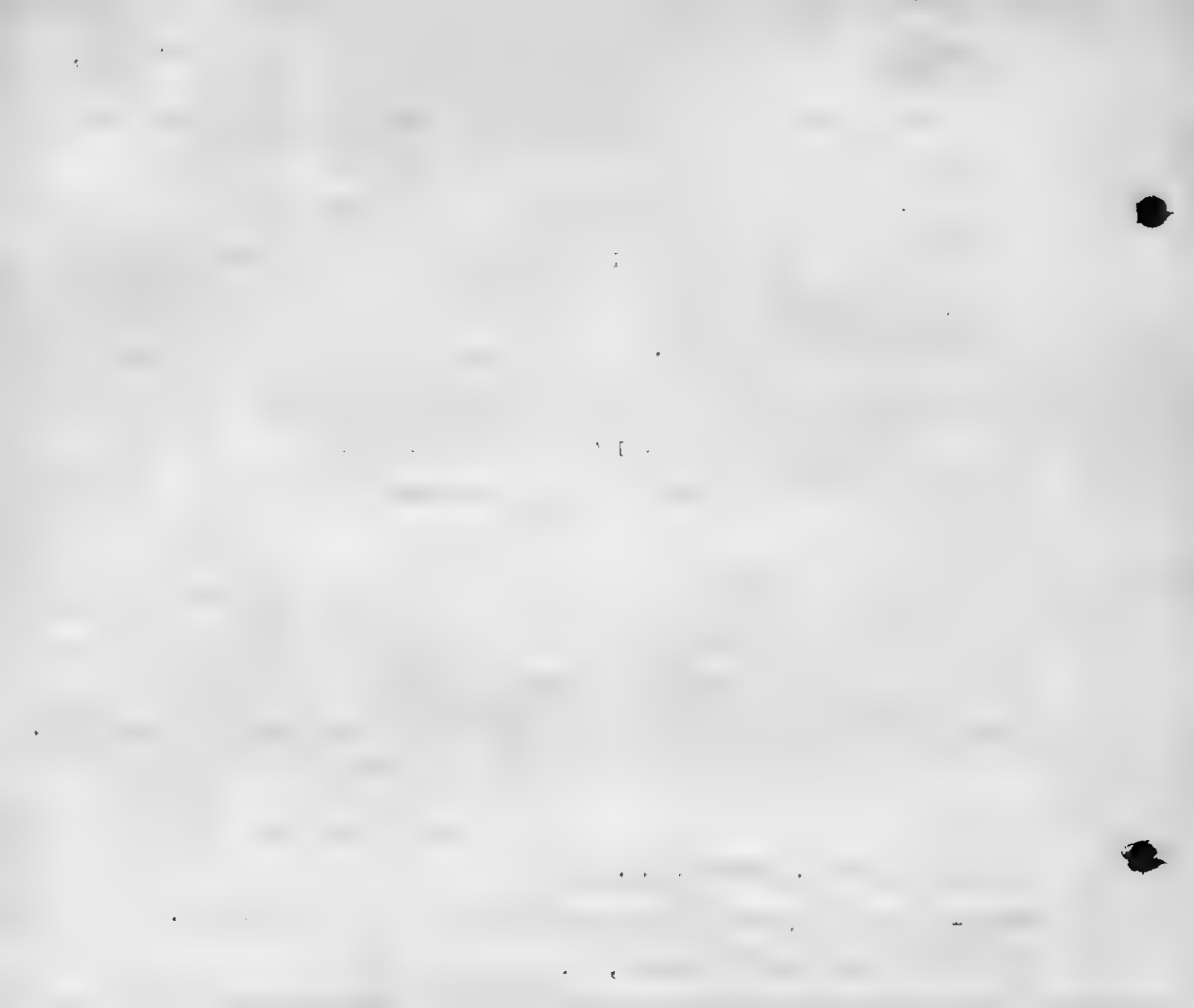
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FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

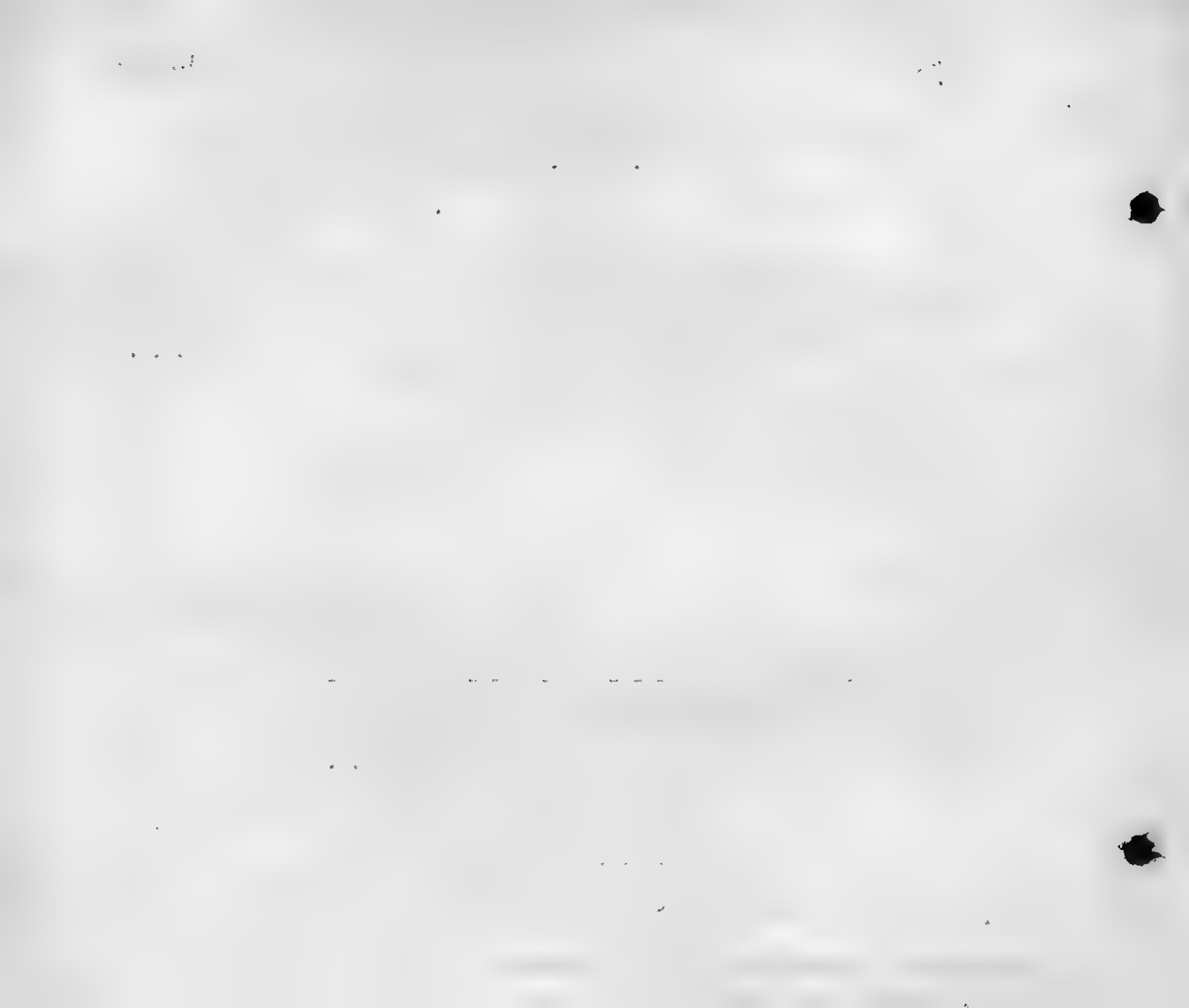
MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Anne Arundel						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Anne Arundel						c. LENGTH OF STAY IN lb Edgewater					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital						d. STREET ADDRESS Woodland Beach					
3. NAME OF DECEASED (Type or print) ROY L FOSTER						4. DATE OF DEATH Month May Day 13 Year 19 62					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 6/27/14		9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months 13 Days 13 Hours 13 Min. 13	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tree Trimmer				10b. KIND OF BUSINESS OR INDUSTRY Comm.				11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ephram Foster						14. MOTHER'S MAIDEN NAME Margaret (Unknown)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)						16. SOCIAL SECURITY NO. 406-09-7164					
17. INFORMANT Fanny Foster- Wife- same as # 2						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun wound of the left chest 976 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) _____					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Shot self in chest					
20c. TIME OF INJURY Hour 8:00 p.m. 5/12 19 62						20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home						20f. (City or town) (County) (State) Edgewater, Anne Arundel, Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Peter W. Rieckert, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Peter W. Rieckert, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, 22b. DATE THEREOF Removal-Burial May 15, 1962						22c. NAME OF CEMETERY OR CREMATORY Cross Roads Cemetery					
22d. LOCATION (City, town, or country) (State) Rt 2 Oneida, Tenn.						24a. REC'D BY REGISTRAR MAY 18 '62					
24b. REGISTRAR'S SIGNATURE Arthur L. Thomas						24c. REGISTRAR'S SIGNATURE Arthur L. Thomas					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician and completely filled in by the funeral director. The law also requires that the death certificate be retained by the funeral director and completely filled in by the funeral director. The law also requires that the death certificate be retained by the funeral director and completely filled in by the funeral director.

VR A15 (4)
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05343 CERTIFICATE OF DEATH 05337											
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 4 yrs. 4 mos. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1223 E. Lanvale Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Hattie Spencer Gardmon				4. DATE OF DEATH Month 5 Day 3 Year 1962							
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 1, 1882		9. AGE (In years last birthday) 80 yrs		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY Unknown				11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joe Spencer				14. MOTHER'S MAIDEN NAME Susie ?				Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Cardiovascular Disease (c) General and Cerebral Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B) 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 1/6 , 19 58 , to 5/3 , 19 62 , that (I) (we) last saw the deceased alive on 5/3 , 19 62 , and that death occurred at 5:30 a.m. , from the causes and on the date stated above.											
22a. SIGNATURE Lionel McHenry Mapp, M.D.				22b. DATE SIGNED May 3, 1962							
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D.				22d. ADDRESS Crownsville State Hospital, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5-6-62				23c. NAME OF CEMETERY OR CREMATORY St. Calvary Cem.			
24. FUNERAL DIRECTOR'S SIGNATURE Rayner Sanders				24a. ADDRESS 217 E. Preston St.				24b. REC'D BY REGISTRAR May 8 '62			
								25b. REGISTRAR'S SIGNATURE Carlton S. Kline			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05344

05338

1. PLACE OF DEATH a. COUNTY <u>AA.</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>167 Gloucester St</u>		2. USUAL RESIDENCE (Where deceased lived, if inst'l on residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>167 Gloucester St.</u>	
3. NAME OF DECEASED (Type or print) <u>Hattie V. Lessner</u>		4. DATE OF DEATH Month <u>May</u> Day <u>17th</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 11th 1879</u>
9. AGE (in years last birthday) <u>82</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dress making</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Annapolis</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles H. Obery</u>		14. MOTHER'S MAIDEN NAME <u>Bertha L. Weaver</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-16-1068</u>	
17. INFORMANT <u>Charles H. Obery</u>		Address <u>167 Gloucester St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u> </u> (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> (b) <u> </u> (c) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 10, 1959</u> to <u>Jan 5, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan 5, 1962</u> , and that death occurred at <u> </u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>James R. Martin</u>		22b. DATE SIGNED <u>5/17/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>		22d. ADDRESS <u>6 SHAW ST. ANNAPOLIS, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 19th 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St Marys Cem</u>		23d. LOCATION (City, town or county) (State) <u>Annapolis Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Surs</u>		25a. REC'D BY REGISTRAR <u> </u> DATE <u>MAY 21 1962</u>	
25b. REGISTRAR'S SIGNATURE <u> </u>			

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5345

05339

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN b. 5 mos. 16 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2322 McCulloh Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) 3-#23022 Anna Estelle (Essie) Green First Middle Last		4. DATE OF DEATH Month 5 Day 7 Year 19 62	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1876
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 5 Days 7	11. IF UNDER 24 HRS. Hours 19 Min. 62
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Stewart		14. MOTHER'S MAIDEN NAME Martha ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease 443X Conditions, if any, which gave rise to immediate cause (b) DUE TO (c), stating the underlying cause last. DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) Osteomyelitis, Right Leg			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. --- p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) ----- (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/21 6:15 to 5/7 19 62 , that (I) (we) last saw the deceased alive on 5/7 19 62 , and that death occurred at 11:15 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Hildegard Heard Reissman M.D.		22b. DATE SIGNED 5/7/62	
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial 5/12/62		23c. NAME OF CEMETERY OR CREMATORY Carver Mem. Park	
23d. LOCATION (City, town or county) (State) Laurel Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Herbert E. Rutter		25a. REC'D BY REGISTRAR MAY 9 '62	
25b. REGISTRAR'S SIGNATURE -----			

36
2



CERTIFICATE OF DEATH

05346

05340

1. PLACE OF DEATH
a. COUNTY Anne Arundel **MARYLAND**
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN b. 1 wk
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town, 10 Annapolis
d. STREET ADDRESS 194 Clay St. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Anne Arundel First Nannie Evelyn Middle GREEN Last GREEN
4. DATE OF DEATH May 10 1962 Month May Day 10 Year 1962

5. SEX Female 6. COLOR OR RACE Negro 7. MARRIED ☒ NEVER MARRIED ☐ B. DATE OF BIRTH Dec. 17, 1895 9. AGE (in years last birthday) 66 yrs. 10. IF UNDER 1 YEAR Months 6 Days 10 11. IF UNDER 24 HRS. Hours 10 Min. 10

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic 10b. KIND OF BUSINESS OR INDUSTRY ***** 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Unknown 14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. Known 17. INFORMANT Robert Green Sr. 194 Clay St., Anna, Md. Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage due to arterial sclerosis
DUE TO (b) Hypertension
DUE TO (c) Cardiovascular disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY Month, Day Year Hour e.m. p.m. 19 5/4 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town, (County, (State)

21. I certify that (I) Robert Green Sr. attended the deceased from May 10, 1962, to May 10, 1962, that (I) we saw the deceased alive on May 10, 1962, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE R. L. Richardson 22b. DATE SIGNED 6:45 PM
22c. PHYSICIAN'S NAME (Type) R. L. Richardson, M.D. 22d. ADDRESS 110 Clay St., Annapolis, Md.

23a. BURIAL, CREMATION REMOVAL (Specify) Burial 23b. DATE THEREOF May 13-62 23c. NAME OF CEMETERY OR CREMATORY Brewer Hill 23d. LOCATION (City, town or county) Annapolis, Maryland (State)

24. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks III ADDRESS Annapolis, Maryland

25a. RECORDING REGISTRY DATE MAY 16 '62 25b. REGISTRAR'S SIGNATURE C. Hicks III

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05341

05341

1. NAME OF DECEASED Type or Print		2. DATE OF DEATH				
WILLIAM E. GREEN		5-20-62				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE B. COUNTY C. CITY OR TOWN D. STREET ADDRESS (If rural, give location)				
Anne Arundel County 309 Riverview Rd.		Md. BALTO. 309 RIVERVIEW RD.				
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days
M	W	Wid.	2-4-90	77		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
W.M.R.R. RETIR.				Md.		U.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? Yes (or unknown) (If yes, give war or dates of service)		
JOSHUA GREEN		ELLEN DE BOW		NO		
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
		FAMILY - AS ABOVE				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH		
4: Chronic Myocardial Degeneration		A) DUE TO		2 yr.		
ANTECEDENT CAUSES		B) DUE TO		2 yr.		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		C) DUE TO				
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN		21. I certify that (I) (this hospital) attended the deceased from		22. I certify that (I) (this hospital) attended the deceased from		19.62 to
5-20		19.62		5-19		19.62
and that in (my) (our) opinion death occurred at		10 A. m.		from the causes and on the date stated above		
23A. SIGNATURE		23B. ADDRESS		23C. DATE SIGNED		
a.c. Solloway		707 E. Fort Ave.		5-21-62		
ATTENDING PHYSICIAN MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> M.D.		24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY
		BURIAL		5-24-62		GLEN HAVEN
		24D. LOCATION (City, town or county)		24E. STATE		
		BALTO.		Md.		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		
MAY 22 '62		Arthur L. Thomas		McCall's Funeral Home		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

05348

05342

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE MARYLAND b. COUNTY A-ARUNDELCG.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE P.O.	c. LENGTH OF STAY IN 1b 2 YRS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE, MD.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 21-1ST AVE MARLEY PARK, MD.		d. STREET ADDRESS 604 ANKAP RD.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last MATTIE GERTRUDE GRIMES		4. DATE OF DEATH Month Day Year MAY 11 1962	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 NOV 1880
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min 81	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWFE		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) FINCASTLE, VIRGINIA
12. CITIZEN OF WHAT COUNTRY? YES		13. FATHER'S NAME GEORGE W. BAKER (DEC)	
14. MOTHER'S MAIDEN NAME MARY LUGER (DEC)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address MRS. MOLLIE WATKINS (daughter) SAME ADDRESS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CARDIAC EDEMA DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CONGESTIVE HEART FAILURE DUE TO 4 mo (c) ARTERIO SCLEROTIC HEART DISEASE 20 YRS			INTERVAL BETWEEN ONSET AND DEATH SUDDEN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) NONE	
20c. TIME OF INJURY Month, Day, Year Hour o. m. X 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X	20f. (City or town) (County) (State) X
21. I certify that I attended the deceased from 1 APRIL, 1962 , to PRESENT , 19____, that I last saw the deceased alive on 27 APRIL, 1962 , and that death occurred at 5⁰⁰ A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED H.F. Manuzak M.D. 425 S. RITCHIE HWY 11 MAY 62 GLEN BURNIE, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/15/62	22c. NAME OF CEMETERY OR CREMATORY Flushing Cemetery
22d. LOCATION (City, town, or county) (State) Flushing Ohio		24a. REC'D BY REGISTRAR DATE MAY 17 '62	
24b. REGISTRAR'S SIGNATURE Hopping & Kirkley		24c. REGISTRAR'S SIGNATURE Glen Burnie Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 1311 West St.,	
3. NAME OF DECEASED (Type or print) Gardiner		4. DATE OF DEATH May 9 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1906
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housing Authority, EXAC, for Annapolis City		9. AGE (In years last birthday) 55 yrs.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Amos L. Hall		14. MOTHER'S MAIDEN NAME Betty L. Patterson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT	
17. ADDRESS Dorothy W. Hall		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4-20-62 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
19. INTERVAL BETWEEN ONSET AND DEATH Immediate 2 years		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) Richard I. Hochman attended the deceased from Jan. 20, 1962 , to May 9, 1962 , that (I) Richard I. Hochman saw the deceased alive on May 9, 1962 , and that death occurred at 6:20 AM from the causes and on the date stated above.			
22a. SIGNATURE Richard I. Hochman		22b. DATE SIGNED 5/9/62	
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.		22d. ADDRESS 59 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 11 1962	
23c. NAME OF CEMETERY OR CREMATORY Mt. Harmony Cemetery		23d. LOCATION (City, town or county) (State) Calvert Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons		25a. REC'D BY REGISTRAR DATE MAY 15 '62	
ADDRESS Annapolis Md		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

05350

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05343

Reg. Dist. No:

1. PLACE OF DEATH
a. COUNTY D. ALCO

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annabopolis c. LENGTH OF STAY IN TB

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Glen Burnie

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.D.M. Anne Arundel Sen. d. STREET ADDRESS 1307 N. Hammonds Ferry Rd. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year
Hawmond Shall 5 30 1962

5. SEX M 6. COLOR OR RACE W 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 3-29-11 9. AGE (In years last birthday) 51 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance 10b. KIND OF BUSINESS OR INDUSTRY Friendship Airport 11. BIRTHPLACE (State or foreign country) Calvert Co., Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Silas Hall 14. MOTHER'S MAIDEN NAME Nettie Grassion

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 2-13-20-9739 17. INFORMANT Mrs. Harriett I. Hall Address Same As #2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac
454.4 DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE E. Linhardt M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 5/30/62
EXAMINER'S NAME (Type) E. Linhardt ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 21 June '62 22c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. PK 22d. LOCATION (City, town, or county) (State) Glen Burnie Md.

23. FUNERAL DIRECTOR'S SIGNATURE R. Singleton ADDRESS Glen Burnie Md. 24a. REC'D BY REGISTRAR JUN 1 '62 24b. REGISTRAR'S SIGNATURE William A. Hume

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enter the date in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years. The law also requires that the death certificate be retained by the funeral director for 4 years. The law also requires that the death certificate be retained by the State Department of Health for 4 years. The law also requires that the death certificate be retained by the State Department of Health for 4 years.

VR AIS (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05351 CERTIFICATE OF DEATH 05344

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		
c. LENGTH OF STAY IN 1b <u>Homewood N/H - 1312 West St.</u>			d. STREET ADDRESS <u>RT. 6 Box 135 - High Point</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>CYRUS B</u>			4. DATE OF DEATH <u>HAYNIE</u> <u>5</u> <u>29</u> <u>1962</u>		
5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>23</u> <u>Dec.</u> <u>1892</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory Worker</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		
10b. KIND OF BUSINESS OR INDUSTRY <u>Revere Cop. & Brass</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>(Unknown)</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>216-10-9896</u>		
17. INFORMANT <u>Mr. Thomas Haynie</u>			Address <u>Same As #2</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>ARTERIOSCLEROSIS, GENERALIZED</u> DUE TO DUE TO (c) <u>UNKNOWN</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 HOURS</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from... <u>5/28</u> , 1962, to... <u>5/29</u> , 1962, that (I) (we) last saw the deceased alive on... <u>5/28</u> , 1962, and that death occurred at <u>3:30</u> AM, from the causes and on the date stated above.					
22a. SIGNATURE <u>Edward S. Beck</u> M.D.					
22b. DATE SIGNED <u>5/30/62</u>					
22c. PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK M.D.</u>					
22d. ADDRESS <u>71 FRANKLIN ST. ANNAPOLIS MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
23b. DATE THEREOF <u>31 May 1962</u>					
23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Pk.</u>					
23d. LOCATION (City, town or county) (State) <u>Glen Burnie Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>R.V. Singleton</u>					
25a. REC'D BY REGISTRAR <u>JUN 1 '62</u>					
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Parnell</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05352

05346

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY in lb 1 mo. 13 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 624 W. Franklin Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William A. Hollin 3-#23224		4. DATE OF DEATH Month 5 Day 10 Year 1962	
5. SEX Male		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 3, 1898	
9. AGE (In years last birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffer	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Hollin		14. MOTHER'S MAIDEN NAME Nancy Roberts	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 570.4 DUE TO Obstruction of Small Intestines Fecal Impaction and Old Peritoneal Adhesions DUE TO Obstruction of Small Intestines Fecal Impaction and Old Peritoneal Adhesions PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days 2 days years 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1/17 to 5/10 , 19 62 , that (I) (we) last saw the deceased alive on 5/10 , 19 62 , and that death occurred at 2:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Hildegard Heard Reissman M.D.		22b. DATE SIGNED 5/10/62	
22c. PHYSICIAN'S NAME (Type or print) Hildegard Heard Reissman, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5.15.62	
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEM. ARLINGTON, VIRGINIA		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Robert F. M. Linn		25a. REC'D BY REGISTRAR DATE MAY 14 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Krams		25c. ADDRESS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05353

05347

Item 9 Film 0515 2/21/62 iwk

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>A APOLIS</u> c. LENGTH OF STAY IN IT <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>S. H. VAL HOSPITAL, ANN, MD.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X A APOLIS</u> d. STREET ADDRESS <u>RT #3 BOX 145</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN ADAM JERSCHIED</u>		4. DATE OF DEATH Month Day Year <u>MAY 13 1962</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5 NOV 1937</u>	
9. AGE (In years last birthday) <u>24</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>	
13. FATHER'S NAME <u>JOHN ADAM JERSCHIED</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH ELWIG</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>JOHN ADAM JERSCHIED RT3 BOX 145 A A, MD</u>	
17. INFORMANT <u>JOHN ADAM JERSCHIED</u>		18. ADDRESS <u>RT3 BOX 145 A A, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line (or (a), (b), and (c)). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a). <u>Cardiac decompensation.</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u>Arterio sclerotic Heart Disease</u> DUE TO (b) <u>Arterio sclerotic Heart Disease</u> DUE TO (c) <u>Arterio sclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Renal cell carcinoma with metastasis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>9 May 1962</u> , to <u>13 May 1962</u> , that (I) (we) last saw the deceased alive on <u>9 May 1962</u> , and that death occurred at <u>11:40 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>George P. Wilson</u>		22b. DATE SIGNED <u>14 MAY 62</u>	
22c. PHYSICIAN'S NAME (Type) <u>GEORGE P. WILSON, M.D.</u>		22d. ADDRESS <u>U.S. N. A. APOLIS, MARYLAND (S AFF)</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 17-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cent. Annapolis</u>		23d. LOCATION (City, town or county) (State) <u>Annapolis MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		25a. REC'D BY REGISTRAR <u>MAY 16 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05354 CERTIFICATE OF DEATH 05348

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL - Severna Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>Box 417</u>	
3. NAME OF DECEASED (Type or print) First <u>ANNE</u> Middle <u>JACKSON</u> Last <u>JACKSON</u>		4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>19 62</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 20, 1895</u>
9. AGE (In years, months, days) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>67</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>	
11. BIRTHPLACE <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Theodous White</u>		14. MOTHER'S MAIDEN NAME <u>Annie Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>James W. Jackson-Box 417 Severna Park, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 420-1 DUE TO (b) <u>Atherosclerotic C-V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(physician)</u> attended the deceased from <u>19 5 5</u> to <u>May 6, 19 62</u> that (I) <u>(20)</u> last saw the deceased alive on <u>May 6, 19 62</u> , and that death occurred at <u>2:40 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert R. Hahn</u>		22b. DATE SIGNED <u>5-7-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert R. Hahn, M.D.</u>		22d. ADDRESS <u>Gov. Ritchie Hwy., Severna Park, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 17-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Carpenters Hill</u>		23d. LOCATION (City, town or county) (State) <u>Severna Park-Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>C.E. Hicks III</u>		25a. REC'D BY REGISTRAR <u>May 16 '62</u>	
ADDRESS <u>Annapolis, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Anne Arundel County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) DEALE c. LENGTH OF STAY in 1b 10 yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deale d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) First Christian Middle Johnson Last Johnson						4. DATE OF DEATH Month May Day 15 Year 1962					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/5/1900		9. AGE (in years last birthday) 60 1/2 yrs.		10. IF UNDER 1 YEAR Months 60 Days 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Commercial		11. BIRTHPLACE (State or foreign country) Christiania, Norway		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Christina Littlejohn		14. MOTHER'S MAIDEN NAME Anna Johansson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) Yes		16. SOCIAL SECURITY NO. 579 145619		17. INFORMANT JAMES E. Payne		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute carbon-monoxide poisoning 890.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Found dead in bed in kitchen - may have been defective refrigerator		20c. TIME OF INJURY Month, Day, Year 5/15/62		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Residence		20f. (City or town) Deale (County) Anne Arundel (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE Rudiger Breiteneker		EXAMINER'S NAME (Type) Rudiger Breiteneker, M.D.		DATE SIGNED May 15, 1962		22a. NAME OF CEMETERY OR CREMATORY ARLINGTON National		22b. DATE THEREOF 5/18/62		22c. LOCATION (City, town, or country) Fort Myer, Va	
23. FUNERAL DIRECTOR Bernard Hardisty		ADDRESS Haltsville road		24a. REC'D BY REGISTRAR MAY 21 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kline					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05356
05350

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY				a. STATE			
Anne Arundel				Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				b. COUNTY			
Crownsville				Baltimore City			
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
1 mo. 2 wks.				Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
Crownsville State Hospital				1511 N. Kenwood Avenue			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
Estelle				5 3 1962			
5. SEX				6. COLOR OR RACE			
Female				Negro			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH			
February 17, 1923				39 yrs.			
9. AGE (In years last birthday)				10. USAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
Unemployed				Unknown			
11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Maryland				US.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Thomas Taylor				Sarah ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO			
No				Unknown			
17. INFORMANT				Address			
Hospital Records							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)							
Hypostatic Pneumonia							
026 X DUE TO							
Cryptococcal Meningitis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
Chronic Brain Syndrome due to Alcoholism. CNS Syphilis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year							
20d. INJURY OCCURRED							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that (I) (th's hospital) attended the deceased from... 3/14, 1962 to 5/3, 1962, that (I) (we) last saw the deceased alive on 5/3, 1962, and that death occurred at 11:30 a.m. from the causes and on the date stated above.							
22a. SIGNATURE							
22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type)							
22d. ADDRESS							
22e. REC'D BY REGISTRAR							
22f. REGISTRAR'S SIGNATURE							
23a. BURIAL, CREMATION, REMOVAL (Specify)							
23b. DATE THEREOF							
23c. NAME OF CEMETERY OR CREMATORY							
23d. LOCATION (City, town or county) (State)							
24. FUNERAL DIRECTOR'S SIGNATURE							
25. ADDRESS							
25a. REC'D BY REGISTRAR							
25b. REGISTRAR'S SIGNATURE							

23a. Burial 5/8/62 23b. MTC Calvary Cem 23c. Brooklyn Md. 23d. 1000 Brantley Ave. 23e. MAY 7 '62 23f. Arthur L. Hanna

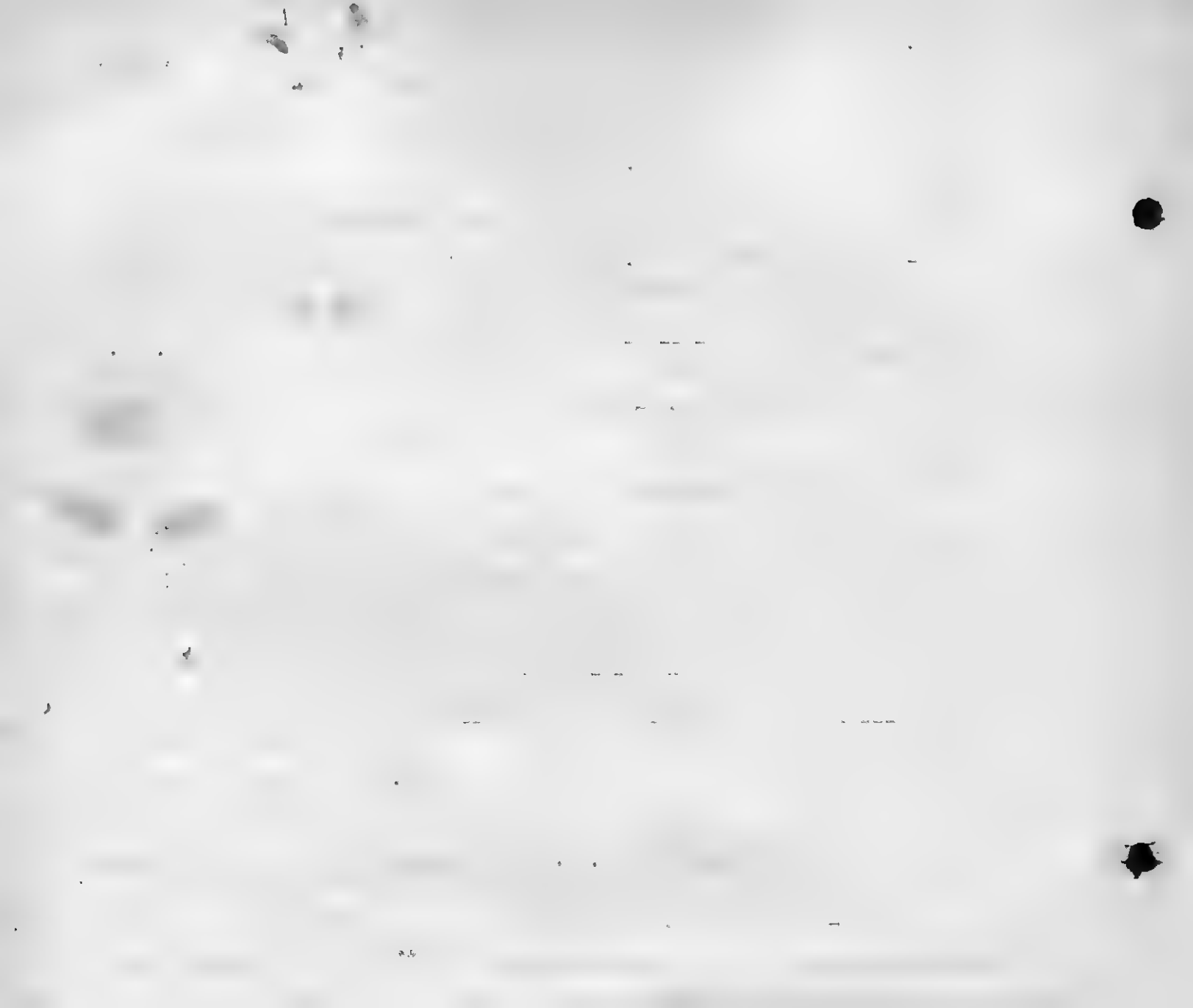


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05357 CERTIFICATE OF DEATH 05351

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN 1b <u>2 mos. 19 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2233 Orem Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>3-#23545 Wallace L. Keys</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input checked="" type="checkbox"/> <u>Separated</u> <input type="checkbox"/> <u>Never Married</u> <input type="checkbox"/> <u>Widowed</u> <input type="checkbox"/> <u>Divorced</u> <input type="checkbox"/>		8. DATE OF BIRTH <u>December 17, 1904</u> 9. AGE (In years last birthday) <u>57</u> yrs. 10. IF UNDER 1 YEAR <u>5</u> Months <u>22</u> Days 11. IF UNDER 24 HRS. <u>19</u> Hours <u>62</u> M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>HAULING</u> 11. BIRTHPLACE (County & State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>Ignatius Keys</u> 14. MOTHER'S MAIDEN NAME <u>Ida</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u> 16. SOCIAL SECURITY NO. <u>215-10-2675</u> 17. INFORMANT <u>Hospital Records</u>		18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Coronary Sclerosis and Thrombosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (e) <u>420.1</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>-----</u>		20c. TIME OF INJURY Month, Day, Year <u>5/22/62</u> Hour <u>12:40</u> a.m. <u>60</u> p.m. 20d. INJURY OCCURRED While <u>at work</u> <input type="checkbox"/> <u>at home</u> <input type="checkbox"/> <u>at work</u> <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u> 20f. (City or town) <u>BALTO. MD.</u> (County) <u>-----</u> (State) <u>-----</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>5/22/62</u> to <u>5/22/62</u> that (I) (we) last saw the deceased and on <u>5/22/62</u> and that death occurred at <u>12:40</u> M. from the causes and on the date stated above. 22a. SIGNATURE <u>Lionel McHenry Mapp, M. D.</u> 22c. PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u>		22b. DATE SIGNED <u>5/22/62</u> 22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>5-26-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>ST. PETERS CEM.</u> 23d. LOCATION (City, town or county) <u>BALTO. MD.</u> (State) <u>-----</u>		25a. REC'D BY REGISTRAR <u>MAY 23 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05358 CERTIFICATE OF DEATH 05352

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena c. LENGTH OF STAY IN 1b 35 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3911 Mountain Road		2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena d. STREET ADDRESS 3911 Mountain Road	
3. NAME OF DECEASED (Type or print) Anna Catherine Kreppel First Middle Last 4. DATE OF DEATH May 29, 1962 Month Day Year		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1905
9. AGE (In years last birthday) 56 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Ventron		14. MOTHER'S MAIDEN NAME Victoria Unk.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mr. William Kreppel	
17. INFORMANT Same		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis DUE TO Coronary arteriosclerotic heart disease DUE TO diabetes mellitus CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
INTERVAL BETWEEN ONSET AND DEATH 30 minutes 5 years 10 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 30, 1944 to May 29, 1962 that (I) (we) last saw the deceased alive on May 27, 1962 and that death occurred at 10 P.M. from the causes and on the date stated above.			
22a. SIGNATURE R.M. McLaughlin		22b. DATE SIGNED 5/29/62	
22c. PHYSICIAN'S NAME (Type) R.M. McLaughlin		22d. ADDRESS 3708 Mountain Rd. Pasadena 4, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 2, 1962	23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cem.	23d. LOCATION (City, town or county) (State) O'Donnell St. Balto., Md.
24. FUNERAL DIRECTOR'S SIGNATURE George J. Gonce		25. REC'D BY REGISTRAR 4 '62	
ADDRESS 4001 Ritchie Hwy. (25)		25b. REGISTRAR'S SIGNATURE Charles S. Evans	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a physician is necessary, it should be executed by the physician. If a coroner is necessary, it should be executed by the coroner. If a medical examiner is necessary, it should be executed by the medical examiner. If a health officer is necessary, it should be executed by the health officer. If a funeral director is necessary, it should be executed by the funeral director. If a registrar is necessary, it should be executed by the registrar. If a medical examiner is necessary, it should be executed by the medical examiner. If a health officer is necessary, it should be executed by the health officer. If a funeral director is necessary, it should be executed by the funeral director. If a registrar is necessary, it should be executed by the registrar.

VR A15ME
5M 1/62

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05359 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** **05353**

1. PLACE OF DEATH
a. COUNTY MARYLAND
b. CITY OR TOWN Anne Arundel
c. LENGTH OF STAY IN 1b Few instants
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Linthicum
e. STREET ADDRESS Baltimore-Washington Expressway

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Florida
b. COUNTY Fort Lauderdale
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town, 2437 Okeechobee Lane)
d. STREET ADDRESS 2437 Okeechobee Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Ralph Pierce Lawson
4. DATE OF DEATH May 30th, 1962
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐
8. DATE OF BIRTH 7/21/95
9. AGE (in years, last birthday) 66 yrs. 66 yrs. 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired telephone engineer
10b. KIND OF BUSINESS OR INDUSTRY East Pepperell, Mass.
11. BIRTHPLACE (State or foreign country) USA
12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME Roswell Lawson
14. MOTHER'S MAIDEN NAME Laura Pierce
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
16. SOCIAL SECURITY NO. Mrs. Downy Lawson (wife)
17. INFORMANT Mrs. Downy Lawson (wife)
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 260X Coronary Occlusion
DUE TO
Conditions, if any, which gave rise to immediate cause (b) Diabetes
(a), stating the underlying cause last. DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II, of item 18)
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
Hour a.m. p.m. 19 While at work ☐ Not While at work ☐
21 I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐ 5/30/62 DATE SIGNED
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or country) Glen Burnie, Md.
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF June 2, 1962
22c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery
22d. LOCATION (City, town, or country) West Haven, Conn.
23. FUNERAL DIRECTOR Hopping and Kirkley, Glen Burnie, Md.
24a. REC'D BY REGISTRAR JUN 4 '62
24b. REGISTRAR'S SIGNATURE Arthur L. K...

05360

CERTIFICATE OF DEATH

05354

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEORGE G MEADE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEORGE G MEADE X			
d. NAME OF HOSPITAL (If not in hospital, give street address) 7428 Van Noy Loop				d. STREET ADDRESS 7428 Van Noy Loop			
3. NAME OF DECEASED (Type or print) First Daniel Middle Joseph Last Leary				4. DATE OF DEATH Month May Day 14 Year 62			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 Oct 1943		9. AGE (In years last birthday) 18 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel F. Leary				14. MOTHER'S MAIDEN NAME Margaret J. Vestroczy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -		INFORMANT Military I.D. Card		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia 754.5 DUE TO Congenital heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Jan 1962 1943						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 14 May , 19 62 , to 14 May , 19 62 , that I last saw the deceased alive on _____, 19____, and that death occurred at 9:22 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Samuel J. Mangus		MC KIMBROUGH ARMY HOSPITAL FT GEORGE G MEADE MD					
PHYSICIAN'S NAME (Type) SAMUEL J. MANGUS, CAPTAIN, MC		KIMBROUGH ARMY HOSPITAL FT GEORGE G MEADE, MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 5/17/62		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE De Witt Donaldson Laurel Md				24a. REC'D BY REGISTRAR DATE MAY 17 '62		24b. REGISTRAR'S SIGNATURE William S. Thomas	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

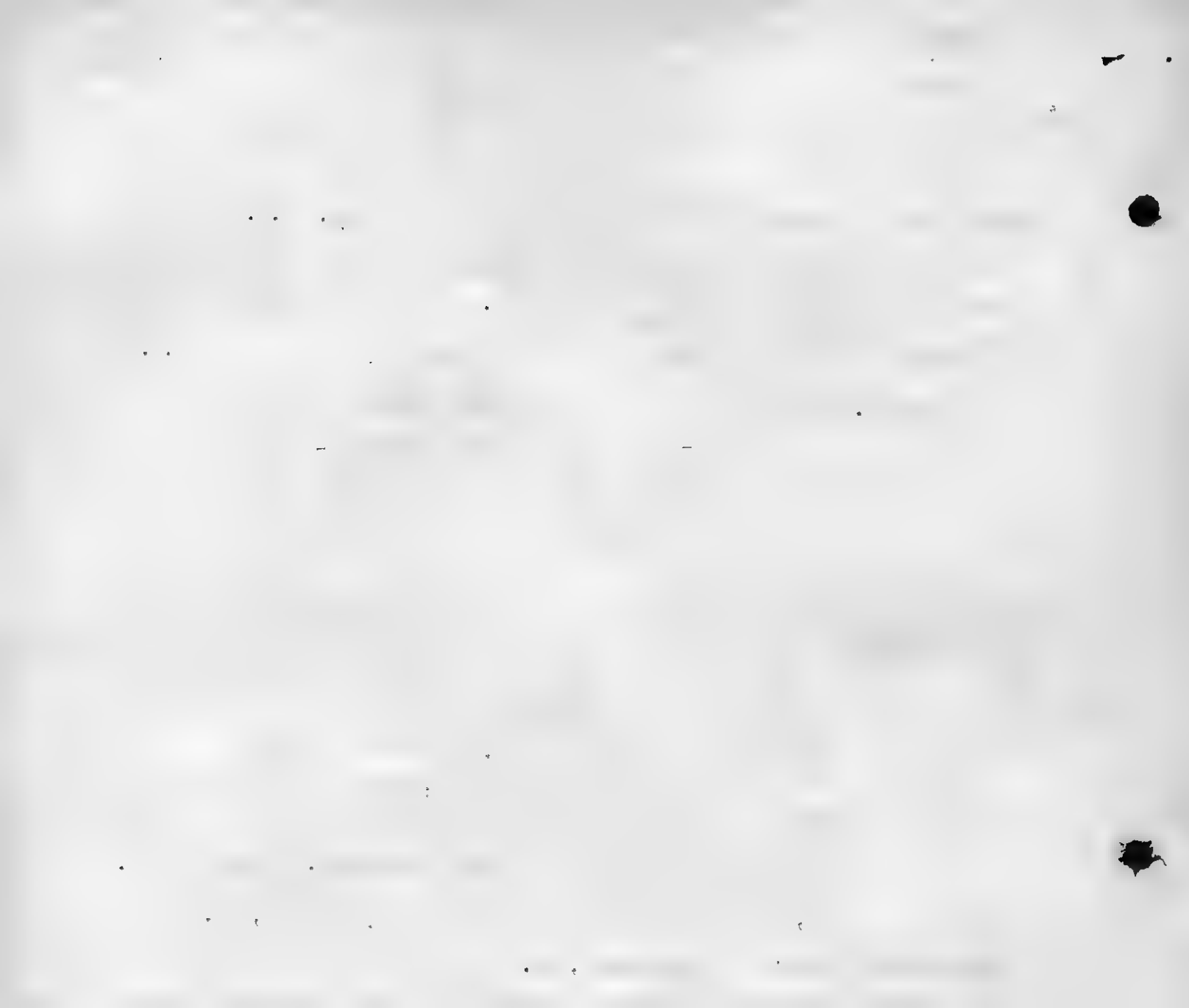
CERTIFICATE OF DEATH

05361

05355

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN b. <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> d. STREET ADDRESS <u>103 2nd Ave., S.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bertha (Bertie) LOWMAN</u> First Middle Last 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jan. 4, 1892</u> 9. AGE (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.		4. DATE OF DEATH <u>May 4 1962</u> Month Day Year 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John T. Lowman</u> 14. MOTHER'S MAIDEN NAME <u>Sarah Hood</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>no</u> (Yes, no, or unknown) (If yes give year or dates of service) 16. SOCIAL SECURITY NO. <u>218-16-1122A</u> 17. INFORMANT <u>Mrs Dorothy Warfield-</u> same as # 2 Address <u> </u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 422.1 DUE TO (b) <u>Arteriosclerotic Cardiovascular Dis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (e) <u>Allergic reaction to penicillin</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) Richard N. Pecker attended the deceased from <u>Apr. 29</u>, 19 <u>62</u> to <u>May 4</u>, 19 <u>62</u>, that (I) (2) last saw the deceased alive on <u>May 4</u>, 19 <u>62</u>, and that death occurred at <u>9:22 AM</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Richard N. Pecker</u> 22c. PHYSICIAN'S NAME (Type) <u>RICHARD N. PECKER</u> 22d. ADDRESS <u>121 Cathedral St., Annapolis, Md.</u> 22b. DATE SIGNED <u>5/6/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>May 7, 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u> 23d. LOCATION (City, town or county) <u>Glen Burnie, Md.</u> 23e. ADDRESS <u>Glen Burnie, Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley</u> 25a. REC'D BY REGISTRAR <u>MAY 8 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Cuning & Pines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The fee 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH

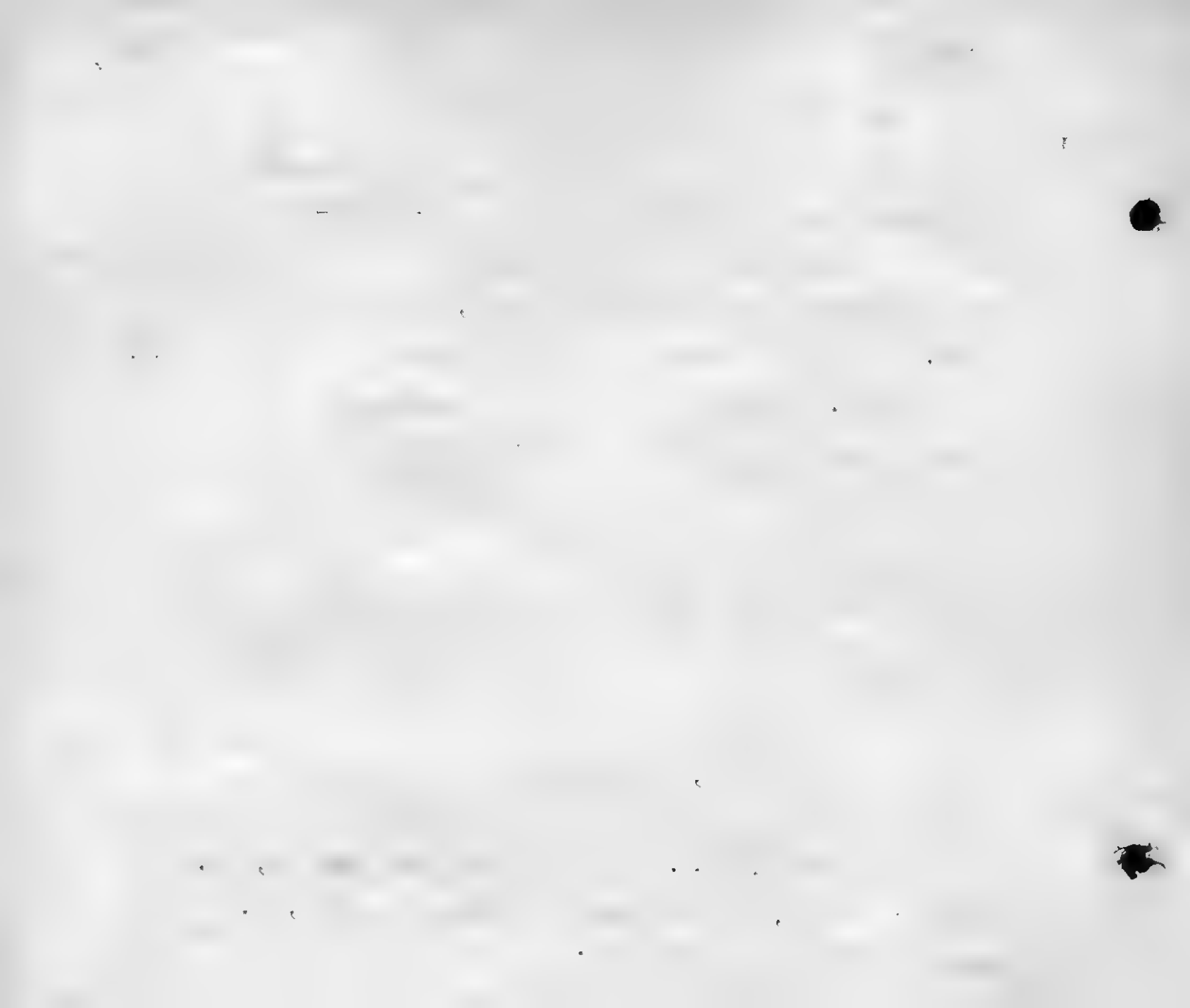
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05362

05356

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN b. 1 day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL - Edgewater d. STREET ADDRESS Rt-1, Box-378	
3. NAME OF DECEASED (Type or print) William First Middle Last 4. DATE OF DEATH May 17 1962 Month Day Year		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH May 5, 1899 9. AGE (in years last birthday) 62 yrs IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Prop. 10b. KIND OF BUSINESS OR INDUSTRY Mariana 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Thomas A. McCarter 14. MOTHER'S MAIDEN NAME Annie Porter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? no (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 3 17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) 180X DUE TO Uremia associated with Conditions, if any, which gave rise to immediate cause (b) hypocalcemia secondary to (a), stating the underlying cause last. (c) undifferentiated adenocarcinoma of left kidney PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) and metastatic to symplegisis pubis		INTERVAL BETWEEN ONSET AND DEATH 24 hours 6 weeks 5 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER). 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, of item 18.)		20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED Whole at work <input type="checkbox"/> Not Whole at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (If deceased) attended the deceased from May 17, 1962 to May 17, 1962 , that (I) (If not) last saw the deceased alive on May 17, 1962 , and that death occurred at 3:15 PM from the causes and on the date stated above.		22a. SIGNATURE Sylvia M. Linn 22c. PHYSICIAN'S NAME (Type) Sylvia Linn, M.D. 22b. DATE SIGNED 5/18/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF May 20, 1962 23c. NAME OF CEMETERY OR CREMATORY Mayo Memorial Cemetery 23d. LOCATION (City, town or county) (State) Mayo, Md.		25a. REC'D BY REGISTRAR MAY 21 '62 25b. REGISTRAR'S SIGNATURE Arthur S. House	

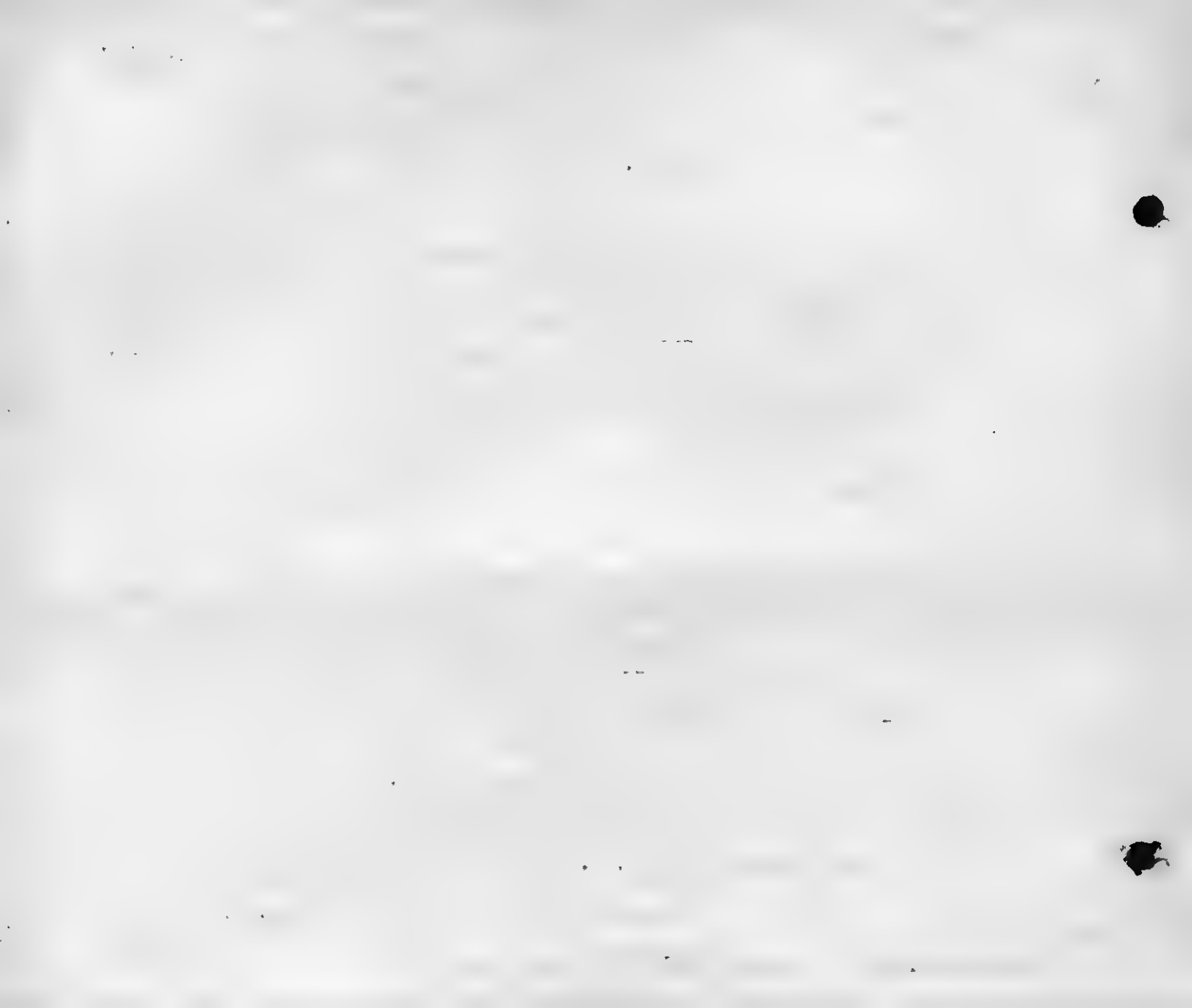


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7, 61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05363 CERTIFICATE OF DEATH 05357

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN b 2 mos. 13 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1430 Carroll Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) 3-#23450 Leon		First Leon		Middle		Last McDonald		4. DATE OF DEATH 5 28 19 62		Month 5		Day 28		Year 19 62													
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1903		9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 5		Days 28		IF UNDER 24 HRS. Hours 19													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jack McDonald		14. MOTHER'S MAIDEN NAME Katie		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia DUE TO (b) Sub arachnoid hemorrhage DUE TO (c) Paralytic Illness Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----		20c. TIME OF INJURY Month, Day, Year Hour a.m. 5/15 p.m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) -----		(County) -----		(State) -----					
21. I certify that (I) (this hospital) attended the deceased from 3/15 1962 , to 5/28 1962 , that (I) (we) last saw the deceased alive on 5/28 1962 , and that death occurred at 6:15 P.M. , from the causes and on the date stated above.		22a. SIGNATURE Lionel McHenry Mapp, M. D.		22b. DATE 5/29/62		22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS -----		22g. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22h. ADDRESS -----		22i. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22j. ADDRESS -----		22k. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22l. ADDRESS -----			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/3/62		23c. NAME OF CEMETERY OR CREMATORY Summerton		23d. LOCATION (City, town or county) Summerton, S.C.		23e. (State) -----		23f. (County) -----		23g. (City or town) -----		23h. (Street) -----		23i. (Apt. No.) -----		23j. (Room No.) -----		23k. (Floor) -----		23l. (Other) -----					
24. FUNERAL DIRECTOR'S SIGNATURE Charles A. Rice		24a. ADDRESS 661 W. Barre St. Baltimore Md.		24b. DATE 6/1/62		24c. REGISTRAR'S SIGNATURE Arthur S. Hume		24d. ADDRESS -----		24e. (City or town) -----		24f. (County) -----		24g. (State) -----		24h. (City or town) -----		24i. (County) -----		24j. (State) -----		24k. (City or town) -----		24l. (County) -----		24m. (State) -----	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05364

05358

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>1 hr.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Shadyside</u> d. STREET ADDRESS <u>Avalon Shores</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Herman</u> Middle <u>John</u> Last <u>MEYER</u>		4. DATE OF DEATH Month <u>May</u> Day <u>8</u> Year <u>1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 10 1886</u> <u>73</u> yrs	
9. AGE (In years last birthday) <u>73</u> Months <u>0</u> Days <u>0</u>		10. IF UNDER 1 YEAR Hours <u>0</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Oil Burner Mechanic</u>		12. CITIZEN OF WHAT COUNTRY? <u>ST. LOUIS, MISSOURI</u>	
13. FATHER'S NAME <u>John Meyer</u>		14. MOTHER'S MAIDEN NAME <u>Weber</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>UN KNOWN</u>		16. SOCIAL SECURITY NO. <u>Marie C. Meyer</u>	
17. INFORMANT <u>SHADYSIDE MD</u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>2 hours</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (e) <u>Bronchial asthma</u>		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
23. TIME OF INJURY Hour <u>19</u> e.m. <u>19</u> p.m. <u>19</u>		24. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>	
25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		26. (City or town) (County) (State)	
27. I certify that (I) <u>Willard F. Smith</u> attended the deceased from <u>Jan</u> <u>1960</u>, to <u>May 8</u>, <u>1962</u>, that (I) <u>Willard F. Smith</u> last saw the deceased alive on <u>May 8</u>, <u>1962</u>, and that death occurred at <u>Shadyside, Md.</u> from the causes and on the date stated above.		28. SIGNATURE <u>Willard F. Smith M.D.</u> <u>10:36 PM</u>	
29. PHYSICIAN'S NAME (Type) <u>Willard F. Smith, M.D.</u>		30. ADDRESS <u>Shadyside, Md.</u>	
31. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		32. DATE THEREOF <u>May 10 1962</u>	
33. NAME OF CEMETERY OR CREMATORY <u>Woodfield</u>		34. LOCATION (City, town or county) (State) <u>Galesville Md.</u>	
35. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Harduty</u>		36. ADDRESS <u>Galesville Md.</u>	
37. REC'D BY REGISTRAR <u>May 15 '62</u>		38. REGISTRAR'S SIGNATURE <u>James L. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05365 CERTIFICATE OF DEATH 05359

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS Epping Forest			
3. NAME OF DECEASED (Type or print) First Middle Last Charles R MORGAN				4. DATE OF DEATH Month 5 Day 26 Year 19 62			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-23-14	
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Post Executive				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Will J. Morgan				14. MOTHER'S MAIDEN NAME Myrtle Bradley			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes World War II				16. SOCIAL SECURITY NO. Hospital Records			
17. INFORMANT Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL EDEMA. 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSION, ESSENTIAL DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 12 HOURS 3 MOS			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, e.g., CIRRHOSIS OF LIVER; PULMONARY EDEMA.				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1962 to J.C. May 1962, that (I) (we) last saw the deceased alive on 5/28/62, and that death occurred at M, from the causes and on the date stated above.							
22a. SIGNATURE Edward S. Peck, M.D.				22b. DATE SIGNED 5/28/62			
22c. PHYSICIAN'S NAME (Type) Edward S. Peck, M.D.				22d. ADDRESS 73 Franklin Street, Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-28-1962		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington Va	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Scayler Sons Annapolis Md				25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
DATE MAY 29 '62				Cuthbert L. Hines			

Reg. Dist. No.

05365

1. PLACE OF DEATH a. COUNTY <u>A. F. Co.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A. F. Co.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X DAVIDSONVILLE MD.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>A. F. GENERAL Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>WILKINS</u> First <u>Otis</u> Middle <u>Munday</u> Last		4. DATE OF DEATH Month <u>MAY</u> Day <u>11</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-22-1887</u>
9. AGE (in years last birthday) <u>75</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CIVIL SERVICE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CIVIL SERVICE</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CARY P. Munday</u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE V. WILKINS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>WWT</u>	
17. INFORMANT <u>NEVA L. Munday</u>		Address <u># 3</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. L. Howard</u>		DATE SIGNED <u>5/1/62</u>	
EXAMINER'S NAME (Type) <u>E. L. Howard</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL - CREMATION, REMOVAL (Specify) <u>CREMATION</u>	22b. DATE THEREOF <u>5-12-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Hyattsville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Lybort</u>		24a. REC'D BY REGISTRAR <u>MAY 15 '62</u>	
ADDRESS <u>Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Evans</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO DEPARTMENT OF HEALTH, MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05367 05361

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park
c. LENGTH OF STAY IN 1b 2 hours
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Old Gravel Pitt, 5500 Block, Belle Grove Rd.

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park
d. STREET ADDRESS 420 / 320 Holy Cross Rd.

3. NAME OF DECEASED (Type or print) Dennis Wayne Neilson
4. DATE OF DEATH May 6th 19 62
5. SEX M 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH 5/19/52
9. AGE (in years last birthday) 9 yrs. IF UNDER 1 YEAR: Months 0 Days 0 IF UNDER 24 HRS.: Hours 0 Min. 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attending school
10b. KIND OF BUSINESS OR INDUSTRY Cumberland, Md.
11. BIRTHPLACE (State or foreign country) Usa
12. CITIZEN OF WHAT COUNTRY? Usa

13. FATHER'S NAME William I. Neilson Sr.
14. MOTHER'S MAIDEN NAME Virginia L. Williams
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. None 17. INFORMANT William I. Neilson (father) Address _____

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Accidental drowning
Conditions, if any, which gave rise to immediate cause (b) 9.2
(a), stating the underlying cause last, (c) DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH. save his pail he fell in the water
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 18.) Was fishing and his fish pail fell in the water in trying to water

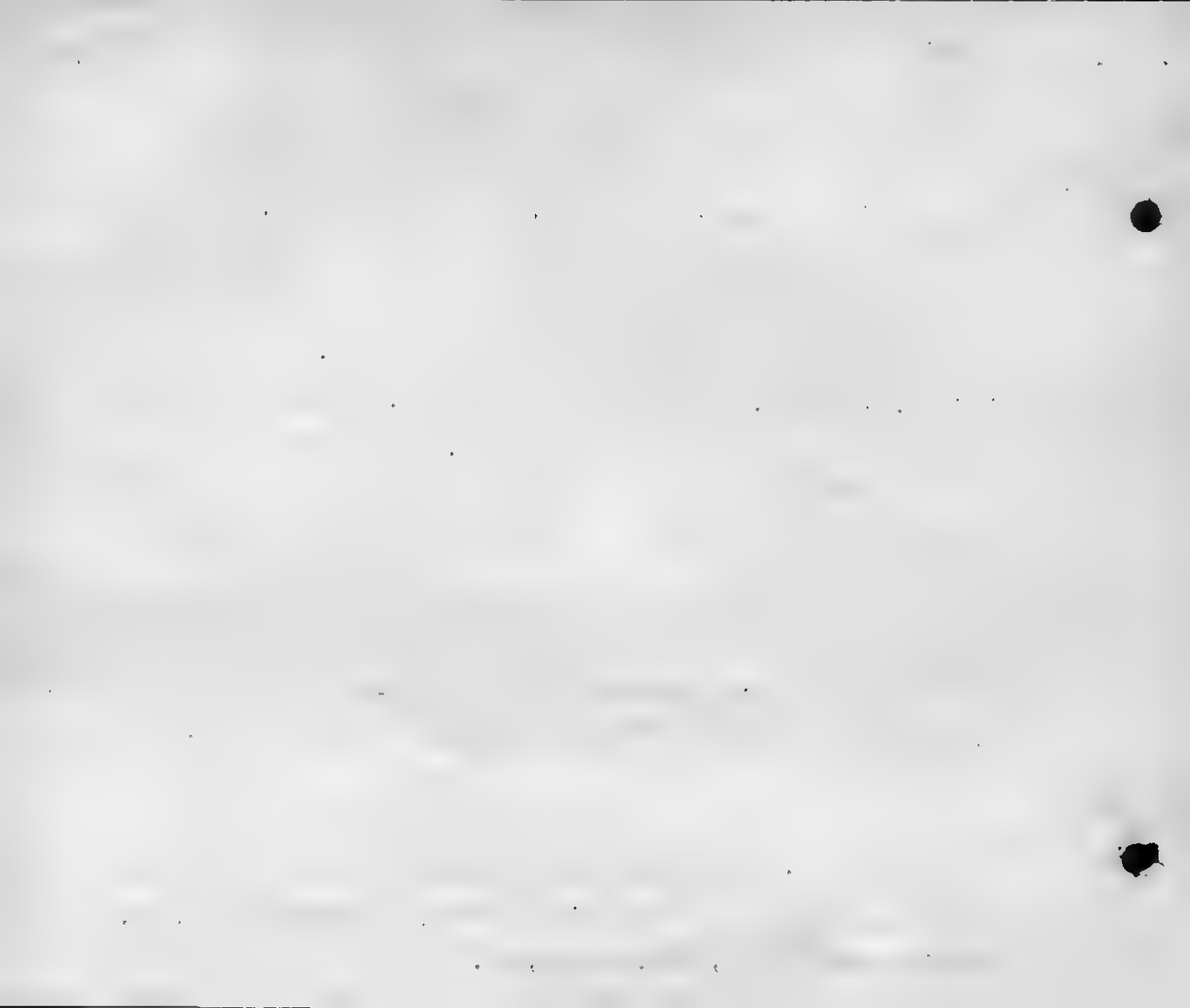
20c. TIME OF INJURY Month, Day, Year 6.30 P.M. 5/6/62 19 62
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Gravel Pitt
20f. (City or town) Brooklyn Park, A.A. (County) Md. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Gustave H. Faubert, M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D. ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 5/6/62
Address (Street, city, town, or county) Glen Burnie, Md. (State) Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 5/9/62 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery 22d. LOCATION (City, town, or county) Baltimore 25, Md. (State) Md.

23. FUNERAL DIRECTOR Hopping and Kirkley, Glen Burnie, Md. ADDRESS _____
24a. REC'D BY REGISTRAR MAY 8 '62 24b. REGISTRAR'S SIGNATURE G. H. Faubert



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05368 CERTIFICATE OF DEATH 05362											
1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSVILLE c. LENGTH OF STAY IN 1b 10 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CROWNSVILLE STATE HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK 22 d. STREET ADDRESS 11 CENTER ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JAMES First H. Middle NELSON Last			4. DATE OF DEATH 5 Month 19 Day 1962 Year			5. SEX MALE			6. COLOR OR RACE NEGRO		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 5/13/1894			9. AGE (In years last birthday) 68 yrs.			10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED STEEL WORKER						11b. KIND OF BUSINESS OR INDUSTRY -			11. BIRTHPLACE (County & State, or foreign country) MARYLAND		
12. CITIZEN OF WHAT COUNTRY? U.S.A.						13. FATHER'S NAME BENI BANKS					
14. MOTHER'S MAIDEN NAME IDA NELSON						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) U.					
16. SOCIAL SECURITY NO. 18-444444444						17. INFORMANT RECORDS OF CROWNSVILLE STATE HOSP. Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE 422.1 DUE TO (b) CHRONIC BRAIN SYNDROME & CEREBRAL ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (c) 422.1 DUE TO (b) CHRONIC BRAIN SYNDROME & CEREBRAL ARTERIOSCLEROSIS (e), stating the underlying cause last. (c) CHRONIC BRAIN SYNDROME & CEREBRAL ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) CHRONIC BRAIN SYNDROME & CEREBRAL ARTERIOSCLEROSIS 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)			(County)			(State)			21. I certify that (I) (this hospital) attended the deceased from 4/30/62 to 5/19/62 , 19....., that (I) (we) last saw the deceased alive on 5/19/62 , 19....., and that death occurred at 5 AM , from the causes and on the date stated above.		
22a. SIGNATURE L. BENEDICT M.D.						22b. DATE SIGNED			22c. PHYSICIAN'S NAME (Type) L. BENEDICT M.D.		
22d. ADDRESS CROWNSVILLE STATE HOSPITAL						22e. REC'D BY REGISTRAR			22f. REGISTRAR'S SIGNATURE		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE THEREOF 5-24-62			23c. NAME OF CEMETERY OR CREMATORY Cleavers Oak Cem.		
23d. LOCATION (City, town or county) Forkier Co. Va.						(State)			24. FUNERAL DIRECTOR'S SIGNATURE MORTON & DYETT 916 PENNA. AVE.		
24. FUNERAL DIRECTOR'S SIGNATURE						24b. ADDRESS			24c. DATE MAY 23 '62		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

05369

05363

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN It Few hours		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 26		d. STREET ADDRESS 2121 Hawkins Point Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Steven Nocar		First		Middle		Last		4. DATE OF DEATH May 7th		Month		Day		Year 1962	
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 6-11-1894		9. AGE (In years last birthday) 67 yrs		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fisherman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Schu		14. MOTHER'S MAIDEN NAME Theresa		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 1 World War	
17. INFORMANT Mr. Anthony Butner (nephew)		Address 4043 V Street, Brooklyn		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accidental Drowning 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH Sudden		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) No eye witness, deceased was found floating on the Creek.	
20c. TIME OF INJURY Hour a. m. Unknown		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Marley Creek		20f. (City or town) Glen Burnie A.A.		(County) Md.		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Gustave H. Faubert, M.D.		EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Glen Burnie, Md.		DATE SIGNED 5/7/62			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 5/11/62		22c. NAME OF CEMETERY OR CREMATORY National		22d. LOCATION (City, town, or county) Baltimore		23. FUNERAL DIRECTOR'S SIGNATURE W. C. Fetter		ADDRESS 130 E. Fetter		24a. REC'D BY REGISTRAR MAY 9 '62		24b. REGISTRAR'S SIGNATURE W. C. Fetter	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any de- necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used on a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05370

05364

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel County</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crownsville State Md</u> c. LENGTH OF STAY in 1b <u>6 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2136 Walbrook Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lucy Owens</u>		4. DATE OF DEATH Month <u>5</u> Day <u>4</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>2-14-20</u>	9. AGE (In years last birthday) <u>42</u> yrs IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Henry Owens</u>		14. MOTHER'S MAIDEN NAME <u>Mary Owens</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Martha Peyton</u>		18. ADDRESS <u>2136 Walbrook Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>420.1</u> DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last <u>2 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c): <u>EKG revealed evidence of previous posterior myocardial infarct 1 year</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-22</u> <u>1953</u> to <u>5-4</u> <u>1962</u> , that (I) (we) last saw the deceased alive on <u>5-4</u> <u>1962</u> , and that death occurred at <u>8:25 P</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Leon W. Whitt</u>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>Leon W. Whitt</u>		22d. ADDRESS <u>Crownsville State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-9-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>mt Green</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>A. McRimmer</u>		25a. REC'D BY REGISTRAR <u>Charles S. Kraus</u>	
25b. REGISTRAR'S SIGNATURE <u> </u>		25c. DATE <u>MAY 8 '62</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Balk 17

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>AA</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Millsville Md.</i> c. LENGTH OF STAY IN 1b <i>Knollwood Manor</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Knollwood Manor</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>AA</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> d. STREET ADDRESS <i>128 Lafayette Ave</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mettie</i> First Middle Last <i>M. Penny</i>		4. DATE OF DEATH Month Day Year <i>5-1-1962</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Apr 17 1879</i>	
9. AGE (In years last birthday) <i>83</i>		10. IF UNDER 1 YEAR Months Days <i>5-1-1962</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Georgia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Newton M. Janas</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Ann Williams</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>A. Velpoe Smith</i> Address <i>2</i>		18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Thrombosis</i> (c) <i>Generalized Arteriosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>24 HOURS</i> <i>10 YEARS</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>1 FEB</i> 1962 to <i>1 MAY</i> 1962 that (I) (we) last saw the deceased alive on <i>25 APR. 1</i> 1962 and that death occurred at <i>7:30 AM</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Edward S. Beck</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 5 1962</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Lakeland Cem</i>		23d. LOCATION (City, town or county) (State) <i>Valdosta Ga.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		25a. REC'D BY REGISTRAR <i>May 3 '62</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>			

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05372

05366

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN IT <u>1 mo. 2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>200 X 2</u>	
3. NAME OF DECEASED (Type or print) <u>3-#23529 Benjamin Perry</u>		4. DATE OF DEATH Last <u>5</u> Month <u>7</u> Day <u>19</u> Year <u>62</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 9, 1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>422.1</u> (a), stating the underlying cause last. DUE TO (c) <u>-----</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>-----</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>-----</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>	20f. (City or town) (County) (State) <u>-----</u>
21. I certify that (I) (this hospital) attended the deceased from <u>4/5</u> <u>1962</u> , to <u>5/7</u> <u>1962</u> , that (I) (we) last saw the deceased alive on <u>5/7</u> <u>1962</u> , and that death occurred at <u>6:10</u> <u>P.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>5/8/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/13/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Head of Creek, Md</u>	23d. LOCATION (City, town or county) (State) <u>Wicomico</u> <u>Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton J. Stewart</u>		25a. REC'D BY REGISTRAR <u>DATE</u> <u>14</u> <u>62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
05373 CERTIFICATE OF DEATH									
Reg. Dist. No.									
1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEORGE G MEADE c. LENGTH OF STAY IN 1b 32 Days					2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 839 BERKSHIRE DRIVE d. STREET ADDRESS HYATTSVILLE, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ANGELO FRANCIS PICQUADO					4. DATE OF DEATH Month May Day 10 Year 1962				
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 22 Sept 1914		9. AGE (In years last birthday) 47 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY US Army		11. BIRTHPLACE (State or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Picquado					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes-27 Mar 1940 to present					16. SOCIAL SECURITY NO. 577382593				
INFORMANT Personnel Records US Army Address Ft George G Meade, Md									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary infarction 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pest operative inguinal hernia INTERVAL BETWEEN ONSET AND DEATH 32 hours									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year 1962 p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from 10 May , 19 62 , to 10 May , 19 62 , that I last saw the deceased alive on 10 May , 19 62 , and that death occurred at 5:40 P. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE David J. Kavee M.D. KIMBROUGH ARMY HOSPITAL FCGM, MD PHYSICIAN'S NAME (Type) DAVID J. KAVEE, CAPTAIN, MC KIMBROUGH ARMY HOSPITAL FCGM, MD									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
Removal		5/12/62		Chamber's Funeral Home		Riverdale, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Earl D. Vetterton 6306 Belair Rd, Baltimore, Md					24a. REC'D BY REGISTRAR DATE MAY 17 '62		24b. REGISTRAR'S SIGNATURE Caring E. Hume		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05374

05368

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN b. <u>32 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U.S. Naval Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> d. STREET ADDRESS <u>803 Trafalger Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles Parker</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>Cauc</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>19 JAN 1886</u> Last Month Day Year 9. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR: Months <u>19</u> Days <u>19</u> Hours <u>62</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CDR</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>USN RET</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Jefferson, Ohio</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Seeley Porter</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Travis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WW-1 & 2</u> 16. SOCIAL SECURITY NO. <u>Norma R Porter</u> 17. INFORMANT <u>Norma R Porter</u> Address <u>2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Pancreas with liver metastases</u> (b) <u>metastases</u> (c) <u>Unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>157X</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office b. dg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from: 17 April 1962 to 19 May 1962, that (I) (we) last saw the deceased alive on 19 May 1962, and that death occurred at P.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>R.G. Williams</u>		22b. DATE SIGNED <u>20 May 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>R.G. WILLIAMS CAPT MC USN</u>		22d. ADDRESS <u>U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 23-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Urlington National</u>		23d. LOCATION (City, town or county) (State) <u>Urlington Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		25a. REC'D BY REGISTRAR <u>DATE MAY 24 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05375 CERTIFICATE OF DEATH 05369

1. PLACE OF DEATH a. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 1 year 2 mos. 29 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital				d. STREET ADDRESS 1619 Druid Hill Avenue			
3. NAME OF DECEASED (Type or print) 3-#23141 James H. Posey				4. DATE OF DEATH Month 5 Day 26 Year 1962			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 21, 1894	
9. AGE (in years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 5 Days 26		IF UNDER 24 HRS. Hours 19 Min. 62			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes W.W.I				16. SOCIAL SECURITY NO. 212-14-0653			
17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Degeneration 1443X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Arteriosclerotic Hypertensive Cardiovascular Disease and Diabetes Mellitus (c) -----						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) -----			
20c. TIME OF INJURY Hour a.m. ----- p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/25 to 5/26 , 19 62 , that (I) (we) last saw the deceased alive on 5/26 , 19 62 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Hildegard Heard Reissman				22b. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.		22c. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-31-62		23c. NAME OF CEMETERY OR CREMATORY Shrocks Mounton S.C.		23d. LOCATION (City, town or county) (State) Shrocks Mounton S.C.	
24. FUNERAL DIRECTOR'S SIGNATURE E. O. Wilson				25a. REC'D BY REG. STAFF 1000 Bonahey Ave.		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
LSM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 7 Film G313 5/24/62 iuk

1. PLACE OF DEATH a. COUNTY AA		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY AA	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Brooklyn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5603 Liberty Terrace		d. STREET ADDRESS 5603 Liberty Terrace	
3. NAME OF DECEASED (Type or print) First John Middle C. Last Pulley		4. DATE OF DEATH Month 5 Day 15 Year 1962	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-3-96
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Fisher-Carr Martins		9. AGE (In years last birthday) 65 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY Louisiana		11. BIRTHPLACE (County & State, or foreign country) Louisiana	
13. FATHER'S NAME unk		14. MOTHER'S MAIDEN NAME unk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		17. INFORMANT Family Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Acute Coronary Thrombosis Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Duodenal Ulcer		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 1, 1957 to May 15, 1962 , that (I) (we) last saw the deceased alive on 5/15/1962 , and that death occurred at 9:35 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Louis J. Glass M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Louis J. Glass, M. D.		22d. ADDRESS 320 Patapsco Ave. # 25	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-18-62	23c. NAME OF CEMETERY OR CREMATORY Green Haven Cem	23d. LOCATION (City, town or county) (State) Green Haven, Md.
24. FUNERAL DIRECTOR'S SIGNATURE James L. K...		25a. REC'D BY REGISTRAR MAY 18 '62	
ADDRESS		25b. REGISTRAR'S SIGNATURE Clayton L. K...	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

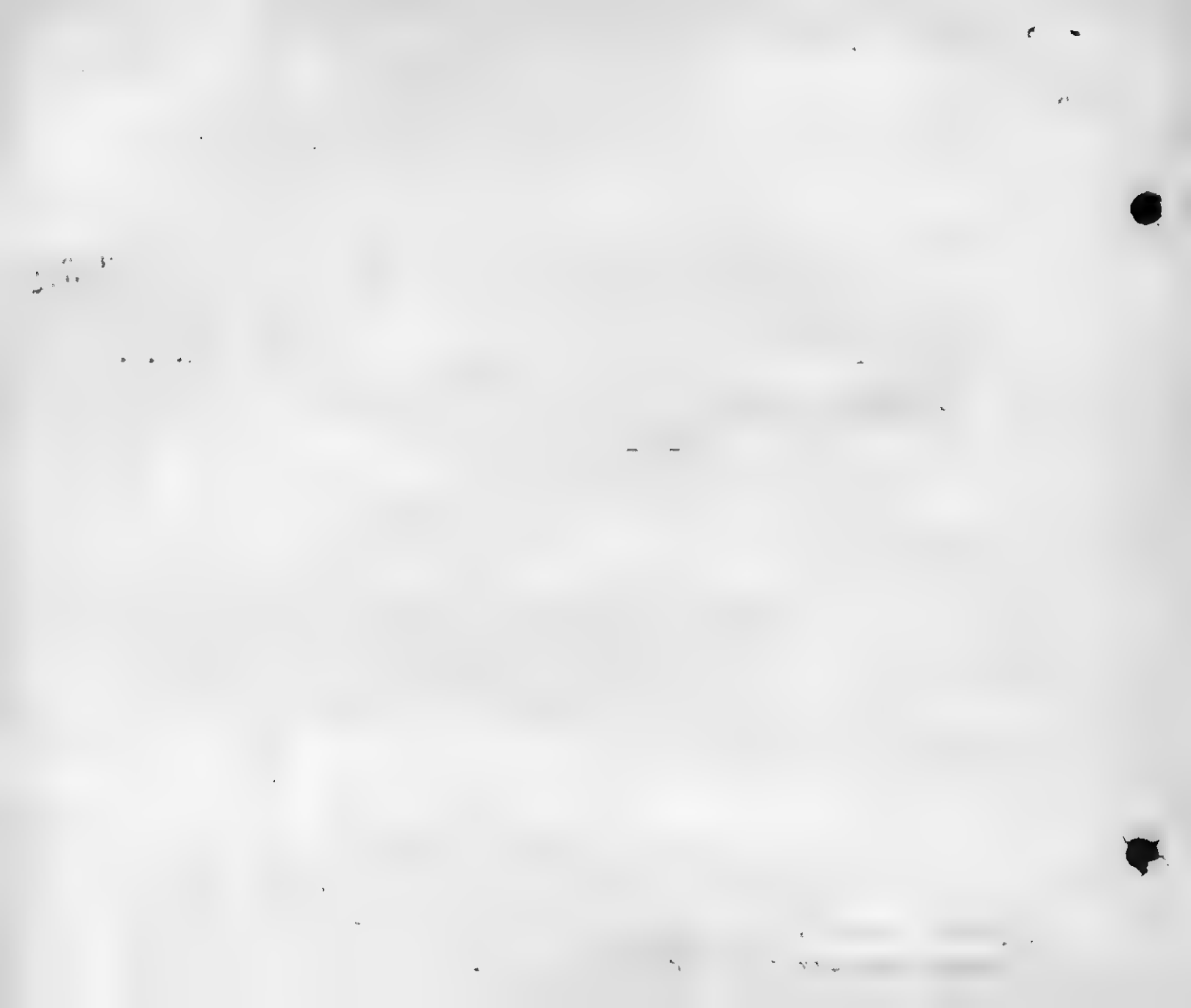
CERTIFICATE OF DEATH

05371

05371

PLACE OF DEATH a. COUNTY <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>Rt. 2, Box 36</u>	
3. NAME OF DECEASED (Type or print) <u>Charles O. PUMPHREY</u>		4. DATE OF DEATH Month <u>5</u> Day <u>4</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-10-33</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>10b. 58 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Charles Pumphrey</u>		14. MOTHER'S MAIDEN NAME <u>Elva Franklin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>177X</u>		16. SOCIAL SECURITY NO. <u>218-91-1922</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Pulmonary metastases</u> (b) <u>Carcinoma of the prostate</u> (c) <u>177X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (the hospital) attended the deceased from <u>5/4</u> , 19 <u>62</u> , to <u>5/4</u> , 19 <u>62</u> , that (I) <u>last</u> saw the deceased alive on <u>5/4</u> , 19 <u>62</u> , and that death occurred at <u>10:35 P.</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard I. Hochman</u>		22b. DATE SIGNED <u>5/5/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman, M.D.</u>		22d. ADDRESS <u>Franklin Street, Annapolis, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8 May/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>	23d. LOCATION (City, town or county) _____ (State) _____ <u>Elkridge Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley</u>		25a. REC'D BY REGISTRAR <u>Glenn Burnie Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE <u>MAY 8 '62</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



VR A15 (4)
15M 7 61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05379

05373

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN b. 4 mos. 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ocean City d. STREET ADDRESS Unknown e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) 3-#23216 Viola First Middle Last				4. DATE OF DEATH Reddick Month 5 Day 17 Year 1962			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 21, 1932	
9. AGE (In years last birthday) 30 yrs.		IF UNDER 1 YEAR Months 5 Days 17		IF UNDER 24 HRS. Hours 17 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	
10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charlie Morrison	
14. MOTHER'S MAIDEN NAME Lulu		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address -----	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Paralytic Ileus (b) Mechanical Obstruction of Intestines (c) ----- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) -----							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) -----		20c. TIME OF INJURY Month, Day, Year Hour 2:15 p.m. 19					
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----					
20f. (City or town) -----		20g. (County) -----					
20h. (State) -----		21. I certify that (I) (the hospital) attended the deceased from 1/15 1962 to 5/17 1962 , that (I) (we) last saw the deceased alive on 5/17 1962 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.					
22a. SIGNATURE <i>Lionel McHenry Mapp</i>				22b. DATE SIGNED 5/17/62		22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.	
22d. ADDRESS Crownsville State Hospital, Maryland				23a. BURIAL, CREMATION, REMOVAL (Specify) 5/27/62			
23b. DATE THEREOF 5/27/62				23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery, Charlotte, N.C.			
23d. LOCATION (City, town or county) (State) -----				24. FUNERAL DIRECTOR'S SIGNATURE <i>William H. Brown</i>			
24a. ADDRESS Washington 191				25a. REC'D BY REGISTRAR MAY 25 '62			
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05380

05374

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>1 Holly ave Severna Park 35 yrs X Severna Park Md</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Severna Park Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>OR INSTITUTION</u>		d. STREET ADDRESS <u>1 Holly ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jane Whitelock Regester</u>		4. DATE OF DEATH Month Day Year <u>5-27 1962</u>	
S. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 24 1879</u>
9. AGE (In years last birthday) <u>82</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Robert Oliver</u>		14. MOTHER'S MAIDEN NAME <u>Miss Edeline DelCorral</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-30-5645</u>	
17. INFORMANT <u>Son Oliver Regester, Severna Park</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sen. Arteriosclerosis</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> to <u>1962</u> 19, that (I) (we) last saw the deceased alive on <u>5-26</u> 19 <u>62</u> and that death occurred at <u>12 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert R. Hahn</u> M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Robert R. Hahn</u>		22d. ADDRESS <u>Severna Park Md</u>	
22b. DATE SIGNED <u>5-27-62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5/29/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LONDON PARK</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOWARD W. HUBBARD</u>		ADDRESS <u>4107 WILKINS AVE</u>	
25a. REC'D BY REGISTRAR DATE <u>MAY 29 62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05381

CERTIFICATE OF DEATH

05376

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN IT 10 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 45 Madison Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Magdalene First ROBINSON Middle May Last 13 4. DATE OF DEATH Month 1962 Day 13 Year 1962		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH March 31, 1882 9. AGE (in years last birthday) 80 yrs. IF UNDER 1 YEAR Months 80 Days 80 IF UNDER 24 HRS. Hours 80 Min. 80	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY U.S.		13. FATHER'S NAME Joseph A. Jackson 14. MOTHER'S MAIDEN NAME Mary Jane Jamison	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no 16. SOCIAL SECURITY NO. none 17. INFORMANT Hospital Records Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 42d. 1 DUE TO (b) infarction Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. arteriosclerosis - CVD DUE TO (c) arteriosclerosis - CVD PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) INTERVAL BETWEEN ONSET AND DEATH 18 hr 10 hr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (the physician) attended the deceased from 1954 19 May 13, 1962 , that (I) (the physician) saw the deceased alive on May 13, 1962 , and that death occurred at 11:05 PM from the causes and on the date stated above. 22a. SIGNATURE Frank M. Shipley 22c. PHYSICIAN'S NAME (Type) Frank M. Shipley, M.D. 22d. ADDRESS 121 Cathedral St., Annapolis, Md.		22b. DATE SIGNED 5/14/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF May 16, 1962 23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery 23d. LOCATION (City, town or county) (State) Annapolis, Md.		25a. REC'D BY REGISTRAR DATE MAY 18 '62 25b. REGISTRAR'S SIGNATURE C. T. King & House	

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
Items 1-10 to be filled out by p/10/62 iuk										
1. PLACE OF DEATH a. COUNTY Pine Anndel. MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			c. LENGTH OF STAY IN 1b 7 years.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL (If not in hospital, give street address) 138 Manor Nursing Home.					d. STREET ADDRESS 2548 Francis Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Ollie First Middle Last ROGERS					4. DATE DEATH May 3rd 1962					
5. SEX F		6. COLOR OR RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/21/878		9. AGE (In years and birth yrs) 83 yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Midwife.		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Granite, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jerry Hall					14. MOTHER'S M maiden name Martha Davis.					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Myocardial Infarct (b) Generalized Arteriosclerosis. (c) DUE TO Hypertensive Arteriosclerotic Cardiovascular Disease										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome due to Cerebral Arteriosclerosis.										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 4/8/1962 to 5/3/1962 that (I) (we) last saw the deceased alive on 5/3/1962, and that death occurred at 12:45 P.M. from the causes and on the date stated above.										
22a. SIGNATURE Lionel M. Henry Mapp, M.D.					22b. DATE SIGNED 5/3/62					
22c. PHYSICIAN'S NAME (Type) Lionel M. Henry Mapp, M.D.					22d. ADDRESS 20 Dean Street, Annapolis Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5-7-62		23c. NAME OF CEMETERY OR CREMATORY A.M.E. ZION			23d. LOCATION (City, town, or county) (State) Granite, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law					ADDRESS 802 Mad. Ave., Balto., Md.		25a. REC'D BY REGISTRAR DATE MAY 7 '62		25b. REGISTRAR'S SIGNATURE Luther S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, pages 3 & 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

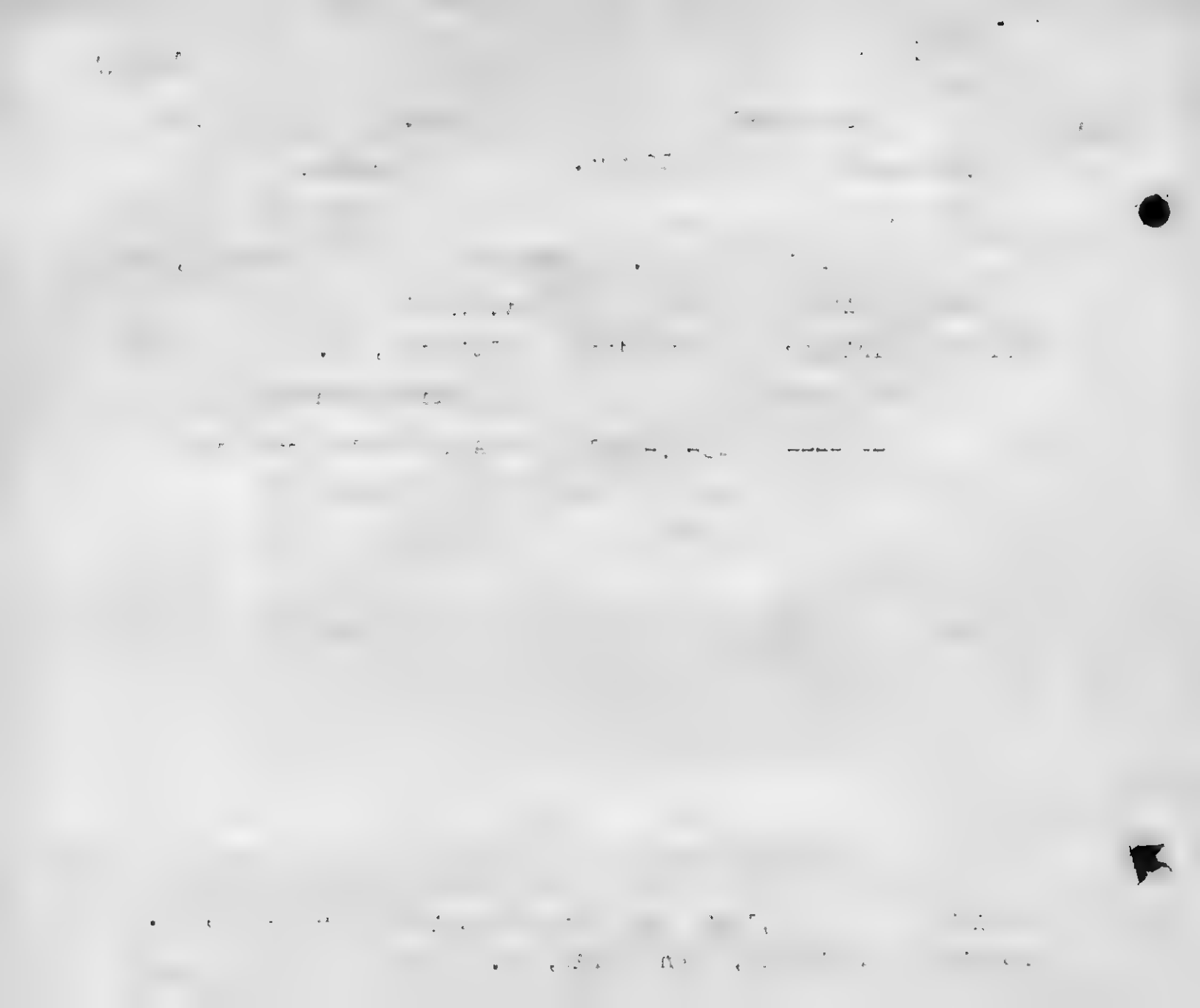
VR A15 (4)
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pasadena c. LENGTH OF STAY in 1b 13 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RFD 2, Box 245		2. USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) a. STATE Md. b. COUNTY AA c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pasadena d. STREET ADDRESS RFD 2, Box 245	
3. NAME OF DECEASED (Type or print) Emil A. Schanken		4. DATE OF DEATH May 18, 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 6, 1884	
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR 2 Months 18 Days 19 Hours 19 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hardwood Finisher		12. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.	
13. CITIZEN OF WHAT COUNTRY? USA		14. FATHER'S NAME Charles Schanken	
15. MOTHER'S MAIDEN NAME Bertha Sandusky		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
17. SOCIAL SECURITY NO. 215-07-0981		18. INFORMANT Mrs Ada Schanken same as 2	
19. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute cerebral thrombosis DUE TO (b) generalized arteriosclerosis DUE TO (c) Carcinoma of the prostate gland - 1 month		20. INTERVAL BETWEEN ONSET AND DEATH 2 days 5 years	
21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of the prostate gland - 1 month		22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II. of item 18.)	
24a. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		24b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
24c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		24d. (City or town) (County) (State)	
25. I certify that (I) (this hospital) attended the deceased from July 15, 1959 to May 18, 1962 ; that (I) (we) last saw the deceased alive on May 17, 1962 , and that death occurred at 6 A.M. from the causes and on the date stated above.		26. SIGNATURE R. M. McLaughlin M.D.	
27. PHYSICIAN'S NAME (Type) R. M. McLaughlin		28. ADDRESS 3708 Mountain Rd. Pasadena, Md.	
29. BURIAL, CREMATION, 23b. DATE THEREOF Burial May 21, 1962		29c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial	
29d. LOCATION (City, town or county) Glen Burnie, Md.		29e. REC'D BY REGISTRAR May 22 '62	
29f. REGISTRAR'S SIGNATURE Hopping and Kirkley, Glen Burnie, Md.		29g. REGISTRAR'S SIGNATURE Carlton S. Hume	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05384 CERTIFICATE OF DEATH 05380

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN 1b <u>7 mos. 26 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>705 W. Lanvale Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>3-#19060 Helen M. Scott</u> f. SEX <u>Female</u> g. COLOR OR RACE <u>Negro</u> h. MARIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> i. DATE OF BIRTH <u>May 8, 1892</u> j. AGE (In years last birthday) <u>70</u> yrs. k. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> l. IF UNDER 24 HRS.: Hours <u>0</u> Min <u>0</u>		4. DATE OF DEATH Month <u>5</u> Day <u>28</u> Year <u>1962</u> m. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> n. KIND OF BUSINESS OR INDUSTRY <u>-----</u> o. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u> p. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Friend</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> 16. SOCIAL SECURITY NO. <u>Unknown</u> 17. INFORMATION <u>Hospital Records</u>		14. MOTHER'S MAIDEN NAME <u>Cornelius Jeter</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>-----</u> DUE TO (c) <u>-----</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dehydration</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>-----</u> p.m. <u>19</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>	
20f. (City or town) <u>-----</u> (County) <u>-----</u> (State) <u>-----</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>10/2</u> <u>1958</u> , to <u>5/28</u> <u>1962</u> , that (I) (we) last saw the deceased alive on <u>5/28</u> <u>1962</u> , and that death occurred <u>2:45 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Lionel McHenry Mapp, M. D.</u>		22b. DATE SIGNED <u>5/28/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 1-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Men. P.R.</u>		23d. LOCATION (City, town or county) <u>Arbutus, Md.</u> (State) <u>-----</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Earl Gilmore</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Hume</u>	
ADDRESS <u>1827 W. North Ave.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 18. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

05385
05381
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum		c. LENGTH OF STAY IN TOWN Few minutes		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE California		b. COUNTY Berkeley		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 45X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Friendship Airport		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS 176 Alvarado Road		g. DATE OF DEATH May 7 19 62		h. AGE (In years last birthday) 81 Yrs.		i. IF UNDER 1 YEAR Months Days Hours Min.	
3. NAME OF DECEASED (Type or print) Clarence Arthur Shuey		4. SEX M		5. COLOR OR RACE W		6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		7. DATE OF BIRTH 1/8/81		8. BIRTHPLACE (State or foreign country) California	
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10. KIND OF BUSINESS OR INDUSTRY		11. CITIZEN OF WHAT COUNTRY? USA		12. FATHER'S NAME John Shuey		13. MOTHER'S MAIDEN NAME Barbara Mathuson		14. WAS EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
15. SOCIAL SECURITY NO.		16. INFORMANT Adm. Allen Shinn, 3038 O St. NW		17. ADDRESS Washington, D.C.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)		19. INTERVAL BETWEEN ONSET AND DEATH Sudden		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		22. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		23. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		24. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		25. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		26. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
27. (City or town)		28. (County)		29. (State)		30. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		31. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		32. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
33. DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		34. DATE SIGNED 5/7/62		35. ADDRESS (Street, city, town, or county) Glen Burnie, Md.		36. ACTUAL SIGNATURE Gustave H. Faubert, M.D.		37. EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		38. 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 5/8/62	
39. 22b. DATE THEREOF 5/8/62		40. 22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		41. 22d. LOCATION (City, town, or county) Baltimore, Md.		42. 23. FUNERAL DIRECTOR Hopping and Kirkley, Glen Burnie, Md.		43. 24. REC'D BY REGISTRAR MAY 8 '62		44. 24b. REGISTRAR'S SIGNATURE C. S. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05386

05382

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel Maryland</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenburnie</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenburnie</u>			
c. LENGTH OF STAY IN 1b <u>14</u> years				d. STREET ADDRESS <u>Nabbs Creek Road</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Box #159</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Barbara</u> Middle <u>0</u> Last <u>Silenskas</u>				4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 4, 1886</u>	
9. AGE (In years, last birthday) <u>75</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Lithuania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Lithuania</u>		13. FATHER'S NAME <u>Deceased</u>		14. MOTHER'S MAIDEN NAME <u>Deceased</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Records</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any which gave rise to immediate cause (b) <u>Arteriosclerotic C.V. disease</u> (a), stating the underlying cause last, (c) DUE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State) <u>None</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>08</u> <u>1955</u> <u>to</u> <u>5/29</u> <u>1962</u> that (I) (we) last saw the deceased alive on <u>5/8</u> <u>1962</u> and that death occurred at <u>7:15</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Sidney R. Fehlert</u>				22b. DATE SIGNED <u>5/29/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>SIDNEY R. FEHLERT</u>				22d. ADDRESS <u>4780 Kensington Ave.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 2, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus</u>		23d. LOCATION (City, town or county) (State) <u>Dundalk, Maryland</u>	
24. GENERAL DIRECTOR'S SIGNATURE <u>Charles W. Kachauskas</u>				25a. REC'D BY REGISTRAR <u>4/62</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>							

CERTIFICATE OF DEATH

05383

1. PLACE OF DEATH
a. COUNTY Galesville Anne Arundel MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Galesville
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galesville
d. STREET ADDRESS

3. NAME OF DECEASED (Type or print)
First Middle Last
Ernest H. Smith

4. DATE OF DEATH
Month Day Year
May 29 1962

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH
WIDOWED ☒ DIVORCED ☐ Sept 12, 1884

9. AGE (In years last birthday) 77 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Carpenter
10b. KIND OF BUSINESS OR INDUSTRY Construction
11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Smith 14. MOTHER'S MAIDEN NAME Betty Wayson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no
16. SOCIAL SECURITY NO. ? 17. INFORMANT Mrs Edward F. Mauk- Daughter- same as #2 Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of lung
163X DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(e), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 months

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19
20d. INJURY OCCURRED While ☐ Not While ☐
at work ☐ at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 1, 1961, to May 29, 1962, that (I) (we) last saw the deceased alive on May 20, 1962, and that death occurred at 5 AM, from the causes and on the date stated above.

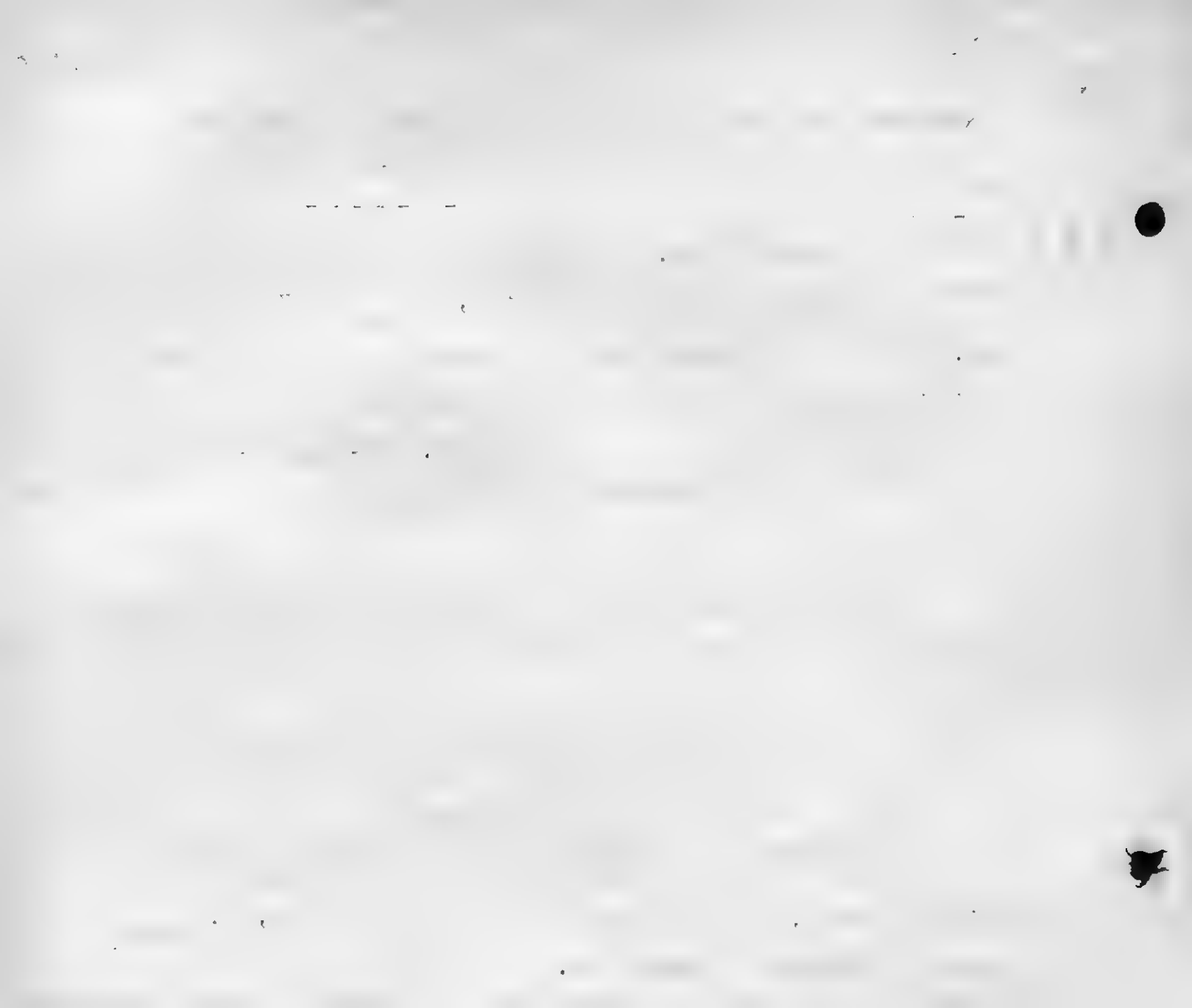
22a. SIGNATURE Willard F. Smith M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 5/29/62
22c. PHYSICIAN'S NAME (Type or print) WILLARD F. SMITH MD
22d. ADDRESS Shady Side, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF May 31, 1962
23c. NAME OF CEMETERY OR CREMATORY Woodfields Cemetery
23d. LOCATION (City, town or county) (State) Galesville, Md.

24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Md.
25a. REC'D BY REGISTRAR JUN 1 1962 25b. REGISTRAR'S SIGNATURE Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND
CERTIFICATE OF DEATH

05388

05384

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN TB <u>35 Min.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institutions; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> d. STREET ADDRESS <u>1112 Leonard Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>P.</u> Last <u>Srsic</u>		4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 3, 1962</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Buren Elsworth SOLLEY</u>		14. MOTHER'S MAIDEN NAME <u>Jacqueline Ellen Smeltz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	
17. INFORMANT <u>Hospital Records</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TUMOR MASSIVE TYPE UNDETERMINED, ORIGINATING FROM ORAL CAVITY</u> DUE TO (b) <u>PREMATURITY</u> DUE TO (c) <u>PREMATURITY</u>	
19. INTERVAL BETWEEN ONSET AND DEATH <u>FROM BIRTH</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-3, 1962</u> to <u>5-3, 1962</u> that (I) (we) last saw the deceased alive on <u>5-3, 1962</u> and that death occurred at <u>11:20 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Raymond P. Srsic</u> M.D.		22b. DATE SIGNED <u>5-4-62</u>	
22c. PHYSICIAN'S NAME (Type or print) <u>Raymond P. Srsic</u>		22d. ADDRESS <u>46 Balto-Anna. Blvd., Glen Burnie, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>5/4/62</u>		23b. DATE THEREOF <u>5/4/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Maryland Anatomy Board</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond C Fink</u> ADDRESS <u>426 Bay Highway</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 16 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Glen Burnie Md</u>		25c. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05389

05385

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 9 Acorn Drive			
3. NAME OF DECEASED (Type or print) First Helena Middle B. Last (Lockett)				4. DATE OF DEATH Month May Day 15 Year 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 11, 1900	
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Thaddeus Lockett				14. MOTHER'S MAIDEN NAME Mary Ellen Britton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no				16. SOCIAL SECURITY NO. 214 05 1253			
17. INFORMANT Mr. Jack Sowers - Husband - same as # 2				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 left ventricular failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerotic heart disease DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 24 hours years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) Myocardial infarct							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (discovered) attended the deceased from November 1961 to May 15, 1962 , that (I) (did) last saw the deceased alive on May 15, 1962 , and that death occurred at 11:25 AM from the causes and on the date stated above.							
22a. SIGNATURE Gerard Church				22b. DATE SIGNED 5/15/62			
22c. PHYSICIAN'S NAME (Type) GERARD CHURCH				22d. ADDRESS 121 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 18, 1962		23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery		23d. LOCATION (City, town or county) (State) Annapolis, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				25a. REC'D BY REGISTRAR MAY 21 '62			
25b. REGISTRAR'S SIGNATURE Arthur S. Hume							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
15M 7/61



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)
ISM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item 8 Film G314 6/4/62 iwk											
05386											
1. PLACE OF DEATH a. COUNTY Anne Arundel				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN b. 2 Bloomsbury Sq.			
2. USUAL RESIDENCE (Where deceased lived, if institution; Res. since before adm. to institution) a. STATE Maryland				b. COUNTY Anne Arundel				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. STREET ADDRESS 2 Bloomsbury Sq.				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) FLONILLA A. SWONTEK				4. DATE OF DEATH May 22 1962				5. SEX Female			
6. COLOR OR RACE White				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH Aug. 25, 1919				9. AGE (In years last birthday) 42 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY own home				11. BIRTHPLACE (Country & State, or foreign country) Virginia			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME William H. Sutphin				14. MOTHER'S MAIDEN NAME Elizabeth McGomery			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. Y				17. INFORMANT Mr. John Swontek- Husband			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? DUE TO (c) ?				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Post Polio Paralysis											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) 19				20g. (County) 19				20h. (State) 19			
21. I certify that (I) (this hospital) attended the deceased from 6-6-1952 to 5-22-1962 , that (I) (we) last saw the deceased alive on April 3, 1962 and that death occurred at 4:45 PM , from the causes and on the date stated above.											
22a. SIGNATURE Edith Rodler				22b. DATE SIGNED May 23, 1962				22c. PHYSICIAN'S NAME (Type) Edith Rodler			
22d. ADDRESS 45 Franklin Street, Annapolis, Md.				22e. REC'D BY REGISTRAR MAY 28 '62				22f. REGISTRAR'S SIGNATURE Carlton L. Hanna			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF May 25, 1962				23c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial			
23d. LOCATION (City, town or county) Annapolis, Maryland				23e. ADDRESS Hopping Funeral Home, Annapolis, Maryland				23f. ADDRESS Hopping Funeral Home, Annapolis, Maryland			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years.

VR A15 (4)
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05391					05387				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)				
a. COUNTY <u>Anne Arundel</u>					e. STATE <u>Maryland</u> f. COUNTY <u>D. D.</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>					d. STREET ADDRESS <u>10 Nabelle Ave.</u>				
3. NAME OF DECEASED (Type or print) <u>Tasker</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
5. SEX <u>Male</u>					6. DATE OF DEATH <u>May 3 1962</u>				
6. COLOR OR RACE <u>Negro</u>					7. DATE OF BIRTH <u>May 3, 1962</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. AGE (In years last birthday) <u>2</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Mins.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				
10b. KIND OF BUSINESS OR INDUSTRY					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Mack Samuel Galloway</u>					14. MOTHER'S MAIDEN NAME <u>Heneritta Tasker</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)					17. INFORMANT <u>Heneritta Tasker</u> Address <u>10 Nabelle Ave., Annapolis, Md.</u>				
16. SOCIAL SECURITY NO.					18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>Fracture of skull & brain injury</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>776X</u> DUE TO <u>Fracture of skull & brain injury</u> (c) <u>776X</u> DUE TO <u>Fracture of skull & brain injury</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>5-3-62</u> to <u>5-3-62</u> , that (I) (we) last saw the deceased alive on <u>5-3-62</u> 19 <u>62</u> , and that death occurred at <u>5-3-62</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>A. T. Allen</u>					22b. DATE SIGNED <u>5/3/62</u>				
22c. PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>					22d. ADDRESS <u>Cathedral St., Annapolis, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>5-9-1962</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>					23d. LOCATION (City, town or county) <u>Annapolis Md.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>					25a. REC'D BY REGISTRAR <u>Arthur S. Kenna</u>				
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>					25c. DATE <u>MAY 15 '62</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05392 CERTIFICATE OF DEATH 05388

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (Outside of corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena (Bayside Beach)</u>	
c. LENGTH OF STAY IN 1b <u>3 yrs.</u>		d. STREET ADDRESS <u>Linthicum Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Linthicum Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Edward Towner Jr.</u>	First Middle Last	4. DATE OF DEATH <u>May 19, 1962</u>	Month Day Year
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 26, 1904</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Man</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>John Edward Towner</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Lee Benson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-10-2886</u>	
17. INFORMANT <u>Mrs. Catherine Towner Same</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Generalized carcinoma</u> 199X DUE TO (b) <u>adenocarcinoma, primary site</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>undetermined, believed to be pancreatic</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>1 year</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>5/18, 1962</u> to <u>5/19, 1962</u> , that (I) (we) last saw the deceased alive on <u>5/18, 1962</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>R.M. McLaughlin</u>			
22b. DATE SIGNED <u>5/21/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>R.M. McLaughlin</u>			
22d. ADDRESS <u>3108 Mountain Rd. Pasadena, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>May 22, 1962</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>			
23d. LOCATION (City, town or county) (State) <u>Ritchie Hwy. A. A. Co., Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Gonce</u>			
ADDRESS <u>4001 Ritchie Hwy. (25)</u>			
25a. REC'D BY REGISTRAR <u>MAY 23 '62</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles S. Harris</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause of death is necessary, please enclose a certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05389

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>Tracys Landing</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tracy's Landing</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>RILEY</u> Last <u>TUCKER</u>		4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 8, 1885</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Riley Tucker</u>		14. MOTHER'S MAIDEN NAME <u>Martha King</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Martha T. Gibson, Tracys Landing, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>chronic occlusion</u> <u>475.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis -</u> DUE TO (c) <u> </u>		INTERVA. BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u> </u> <u> </u> <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Emily H. Wilson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Emily H. Wilson</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 19, 1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Harmony Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Nr. Owings, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hutchins Funeral Home Owings Md.</u>		24a. REC'D BY REGISTRAR <u>MAY 22 '62</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

DATE SIGNED
5/18/62

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

053394

05390

Item 9 Film G313 5/23/62 iwk

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN 1b <u>1 mo. 15 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u> d. STREET ADDRESS <u>Unknown Hammond Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>3-#23511 Henry E. Turner</u>		4. DATE OF DEATH Month <u>5</u> Day <u>16</u> Year <u>1962</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>1875 - Dec. 21, 86</u>		9. AGE (In years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown School teacher Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Unknown Charles Turner</u>				14. MOTHER'S MAIDEN NAME <u>Unknown Harriet Turner</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Unknown No</u> 16. SOCIAL SECURITY NO. <u>Unknown 213-01-8434</u> 17. INFORMANT <u>Unknown Hospital Records</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) <u>Cardiac Decompensation</u> 443X DUE TO <u>Arteriosclerotic Hypertensive Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Brain Syndrome Associated with above</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)									
20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that (I) (this hospital) attended the deceased from <u>3/31</u> <u>1962</u> , to <u>5/16</u> <u>1962</u> , that (I) (we) last saw the deceased alive on <u>5/16</u> <u>1962</u> , and that death occurred at <u>8:00</u> <u>M.</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Hildegard Heard Reissman</u>				22b. DATE <u>5/16/62</u>		22c. PHYSICIAN'S NAME (Type) <u>Hildegard Heard Reissman, M. D. Crownsville State Hospital, Maryland</u>							
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>MAY 19, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Richards Cemetery</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dashiell-Easton</u>				25a. REC'D BY REGISTRAR <u>MAY 21 '62</u>		25b. REGISTRAR'S SIGNATURE <u>C. Albert S. Howard</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

05395

05391

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY QUEEN ANNE			
b. CITY OR TOWN (If outside corporate limits, write FT GEORGE G MEADE)				c. CITY OR TOWN (If outside corporate limits, write BOZMAN)			
d. NAME OF HOSPITAL (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL				d. STREET ADDRESS -			
3. NAME OF DECEASED (Type or print) First Julia Middle Lackey Last VanBibber				4. DATE OF DEATH Month May Day 16 Year 1962			
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 10, 1908		9. AGE (In years last birthday) 54 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Same		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME M.O. Lackey				14. MOTHER'S MAIDEN NAME Mary Myer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Unknown		INFORMANT (Daughter) Mrs Mary Jane VanBibber Orr Bozman, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: Adenocarcinoma of the ovary IMMEDIATE CAUSE (a) 17.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 14 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 61 to 16 May , 19 62 , that I last saw the deceased alive on 16 May , 19 62 , and that death occurred at 6:30 P M, from the causes and on the date stated above.							DATE SIGNED
ACTUAL SIGNATURE David J. Kavee		ADDRESS (Street, city or town, state) KIMBROUGH ARMY HOSPITAL FT G G MEADE, MD					
PHYSICIAN'S NAME (Type) DAVID J. KAVEE, CAPTAIN, MC		KIMBROUGH ARMY HOSPITAL FT G G MEADE, MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 19, 1962		22c. NAME OF CEMETERY OR CREMATORY Speciation Cemetery		22d. LOCATION (City, town, or county) (State) Perryman Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Delville Conahan, Laurel Md				24a. REC'D BY REGISTRAR DATE MAY 22 '62		24b. REGISTRAR'S SIGNATURE C. Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

05396

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05392

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		c. LENGTH OF STAY IN 1b L	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Medary A		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena	
3. NAME OF DECEASED (Type or print) Robert Crawford Wade		4. DATE OF DEATH Month MAY Day 13 Year 1962	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10 1924
9. AGE (In years last birthday) 37 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor - RTR		10b. KIND OF BUSINESS OR INDUSTRY Same	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob Crawford Wade		14. MOTHER'S MAIDEN NAME Lois Catherine Shueker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) Yes		16. SOCIAL SECURITY NO. WW II	
17. INFORMANT Lois Catherine Wade		Address Box 484 Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 288X DUE TO Coronary Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cout DUE TO Cout (c)			INTERVAL BETWEEN ONSET AND DEATH 5 min 2 yrs. 3 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/8 19 62 to 5/12 19 62 that (I) (we) last saw the deceased alive on 3/28 19 62 and that death occurred at — M, from the causes and on the date stated above.			
22a. SIGNATURE R. W. Richard		22b. DATE SIGNED 5/13/62	
22c. PHYSICIAN'S NAME (Type) R. W. RICHARD		22d. ADDRESS 710-Cortez Rd. Glen Burnie	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/16/62	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial		23d. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley		25a. REC'D BY REGISTRAR May 17 '62	
25b. REGISTRAR'S SIGNATURE Charles E. Kline			

05397

CERTIFICATE OF DEATH

05393

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEORGE G MEADE				c. LENGTH OF STAY IN 1b -			
d. NAME OF HOSPITAL (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DAVID Middle FRANK Last WALKER				4. DATE OF DEATH Month 25 Day MAY Year 1962			
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 April 1899	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Service(Retired)				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Florida	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes-Dates unknown				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT (Son) LeRoy Walker Jackson Grove Rd Odenton, Md				Address			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 260 X DUE TO Coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 10 days 1-2 yrs. ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 5/14 , 19 62 , to 5/25 , 19 62 , that I lost saw the deceased alive on 5/25 , 19 62 , and that death occurred at 4 P M, from the causes and on the date stated above ADDRESS (Street, city or town, state) 203 West Maple Rd Linthicum Heights, Md DATE SIGNED 5/25/62							
ACTUAL SIGNATURE Chas. L. Ball Jr. M.D.							
PHYSICIAN'S NAME (Type) Charles L. Ball MD				203 West Maple Rd Linthicum Heights, Md			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 28th May 1962		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.		22d. LOCATION (City, town, or county) (State) Fort Meyer, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R. J. English				ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE MAY 20 '62	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7,61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05398

05394

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS 125 Colvin Street	
3. NAME OF DECEASED (Type or print) John		4. DATE OF DEATH Month 5 Day 27 Year 1962	
S. SEX Male		6. COLOR OR RACE Negro	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 30, 1894	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe-Fitter		9. AGE (In years last birthday) 67	
13. FATHER'S NAME John Washington		11. BIRTHPLACE (County & State, or foreign country) Maryland	
14. MOTHER'S MAIDEN NAME Roberta		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 1917-1919		16. SOCIAL SECURITY NO. 217-09-3112	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (b) Decubitus Ulcers (c), stating the underlying cause last, (c) Parkinson's Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Chronic Brain Syndrome due to Cerebral Arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 6/5 a.m. 9:25 p.m. 5/27 19 62			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6/5 9:25 to 5/27 1962 , that (I) (we) last saw the deceased alive on 5/27 1962 , and that death occurred at 6:25 a.m. from the causes and on the date stated above.			
22a. SIGNATURE Lionel McHenry Mapp			
22b. DATE SIGNED 5/28/62			
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.			
22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			
23b. DATE THEREOF 6/1/62			
23c. NAME OF CEMETERY OR CREMATORY 1000 Brantley Ave.			
23d. LOCATION (City, town or county) (State) Frederick Md.			
24. FUNERAL DIRECTOR'S SIGNATURE E. O. Wilson			
25a. REC'D BY REGISTRAR DATE MAY 31 '62			
25b. REGISTRAR'S SIGNATURE Arthur L. Hines			

3 .



05399

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05395

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEORGE G MEADE				c. LENGTH OF STAY IN TB 3 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LEONARD Middle JEROME Last WASHINGTON				4. DATE OF DEATH Month May Day 9 Year 19 62			
5. SEX Male		6. COLOR OR RACE Negroid		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 14, 1961	
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY -			
11. BIRTHPLACE (State or foreign country) GERMANY				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME LOUIS WASHINGTON JR				14. MOTHER'S MAIDEN NAME MARY LEE MAJOR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO -			
17. INFORMANT Father				Address 7234D Johnston St FGGM, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia							
DUE TO Hydrocephalus							
DUE TO Sturge-Weber Disease							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 9 May 19 62 to 9 May 19 62 , that I last saw the deceased alive on 9 May 19 62 , and that death occurred at 9:15 P.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE William B. Sembrot				MC KIMBROUGH ARMY HOSPITAL FT GEORGE G MEADE			
PHYSICIAN'S NAME (Type) WILLIAM B. SEMBROT, CAPTAIN, MC				MD KIMBROUGH ARMY HOSPITAL FT GEORGE G MEADE MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-15-62		22c. NAME OF CEMETERY OR CREMATORY Long Point Cem		22d. LOCATION (City, town, or county) (State) MT Pleasant, S.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Chas C Wilson				24a. REC'D BY REGISTRAR DATE MAY 14 '62			
ADDRESS 1000 something Ave				24b. REGISTRAR'S SIGNATURE Clifton S. Hanes			

(M) 50



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7-61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
05400											
05396											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DEALE</u> c. LENGTH OF STAY IN 1b <u>60 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institutions Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DEALE</u> d. STREET ADDRESS <input type="checkbox"/> IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Owen Welch</u>						4. DATE OF DEATH Month Day Year <u>May 20 1962</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/13/02</u>		9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN & Farmer</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Seafood - Tobacco</u>					
11. BIRTH-PLACE (County & State, or foreign country) <u>Deale Md.</u>						12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <u>Thomas F. Welch</u>						14. MOTHER'S MAIDEN NAME <u>IDA MAE DEALE</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or details of service) <u>NO</u>						16. SOCIAL SECURITY NO. <u>218 36 3931</u>					
17. INFORMANT <u>EDNA M. WELCH DEALE MD</u>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung & metastases to neck and lumbar vertebrae</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1, 1961</u> , to <u>May 20, 1962</u> that (I) (we) last saw the deceased alive on <u>May 19, 1962</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Willard F. Smith</u> M.D.						22b. DATE SIGNED <u>5/21/62</u>					
22c. PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH, MD</u>						22d. ADDRESS <u>Shady Side, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						23b. DATE THEREOF <u>May 22, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Deale</u>		23d. LOCATION (City, town or county) (State) <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>						25a. REC'D BY REGISTRAR DATE <u>MAY 29 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. ATSM(E)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05397

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A. A. General Hospt.</u>		d. STREET ADDRESS <u>1180 Tyler Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Emma Roberts Windsor</u>		4. DATE OF DEATH Month Day Year <u>5-29-1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-12-1897</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>AA, Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Price</u>		14. MOTHER'S MAIDEN NAME <u>Emma Avery</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Leslie H. Windsor</u>		Address <u>7D</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ladroe</u> <u>4344</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adrenal</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhart</u>		DATE SIGNED <u>5-25-62</u>	
EXAMINER'S NAME (Type) <u>E. Linhart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 1-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion Cemetery</u>		22d. LOCATION: (City, town, or county) (State) <u>Mt Zion Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sr</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 4 '62</u>	
ADDRESS <u>Annapolis Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur P. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY AA b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEALE c. LENGTH OF STAY IN 1b 52 YRS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD b. COUNTY AA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEALE d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Hattie L Windsor 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH OCT. 2 1871 9. AGE (In years, last birthday) 90 IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS.: _____				4. DATE OF DEATH May 15 1962 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postmistress 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) TYASKIN Md. 12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME ISAAC J. STREET 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO 16. SOCIAL SECURITY NO. 17. INFORMANT NORMA WINDSOR DEALE MD Address _____				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Arteriosclerotic heart disease (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Permeious anemia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 1960 to May 15, 1962 , that (I) (we) last saw the deceased alive on May 14 1962 , and that death occurred at 2 AM , from the causes and on the date stated above. 22a. SIGNATURE Willard F. Smith MD 22b. PHYSICIAN'S NAME (Type) WILLARD F. SMITH 22c. ADDRESS Shady Side, Md.				22d. DATE SIGNED 5/15/62 23a. BURIAL, CREMATION, REMOVAL (Specify) Buried 23b. DATE THEREOF MAY 17 1962 23c. NAME OF CEMETERY OR CREMATORY SHERBERT 23d. LOCATION (City, town or county) DEALE MD (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Bernard Harduty Salisbury ADDRESS _____ 25a. REC'D BY REGISTRAR MAY 21 '62 DATE 25b. REGISTRAR'S SIGNATURE Arthur L. Finner							

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH
24 hours
year

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 24 hours may be retained by the hospital or attending physician, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05403 CERTIFICATE OF DEATH 05399

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	
c. LENGTH OF STAY IN 1b <u>44 yrs.</u>		d. STREET ADDRESS <u>#700 Stewart Ave., S.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>#700 Stewart Ave., S.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILHELMINA C. JOCKENFUSS</u>		4. DATE OF DEATH <u>May 1, 1962</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11th April 1878</u>	
9. AGE (in years last birthday) <u>84 yrs.</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11c. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gotlieb Engler</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Schutke</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Alma Lietzau</u>		Address <u>Glen Burnie, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>44</u> DUE TO <u>Cerebral Hemorrhage</u> <u>Hypertensive Cerebro-Vascular Dis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-27</u> 19 <u>62</u> to <u>4-30</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>4-30-62</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles R. MacDonald, M.D.</u>		22b. DATE SIGNED <u>5-1-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles R. MacDonald, M.D.</u>		22d. ADDRESS <u>202 Grain Highway, Glen Burnie, Md.</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>Burial</u> <u>4th May 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Ch. Cemetery</u>	
23d. LOCATION (City, town or county) (State) <u>Violetteville, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAY 3 '62</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Richard E. Engler</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

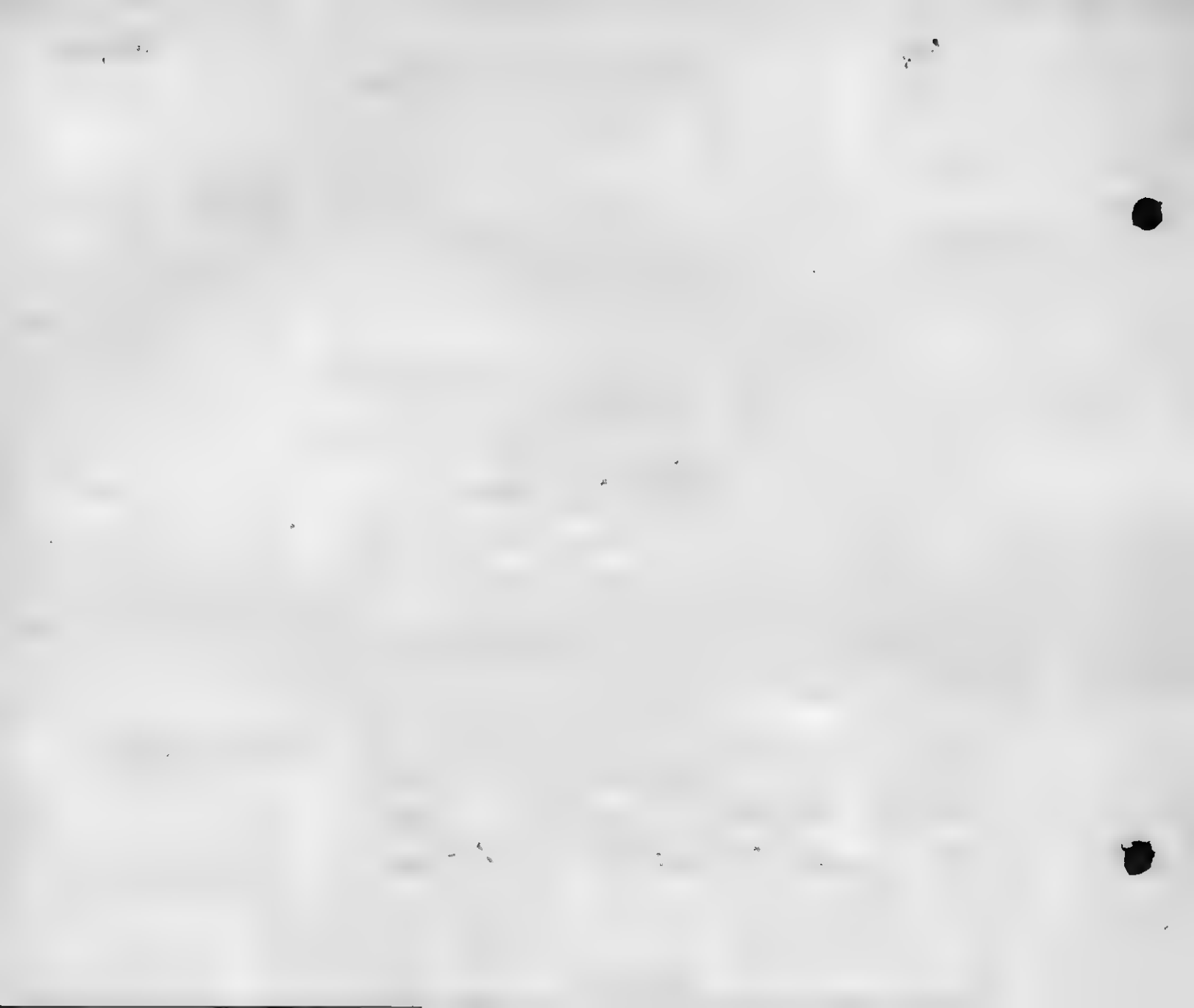
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05404 CERTIFICATE OF DEATH 05400

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL ST. MARGARETS</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ST. MARGARETS RD.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A. Co.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ST. MARGARETS</u> d. STREET ADDRESS <u>ST. MARGARETS RD.</u>		
3. NAME OF DECEASED (Type or print) <u>NEOMA E. Wollett</u>		DATE OF DEATH Month <u>5</u> Day <u>21</u> Year <u>1962</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 23rd 1913</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>21</u> Hours <u>19</u> Min. <u>62</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>WILLIAM KNOWLES</u>		14. MOTHER'S MAIDEN NAME <u>ROSA JAMES</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>CHARLES B. Wollett #2</u>		
17. INFORMANT <u>Charles B. Wollett</u>		Address <u>#2</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Breast, RX.</u> DUE TO (c) <u>17</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>2 1/2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>10-14-59</u> to <u>5-21-1962</u> and that death occurred at <u>8:00</u> P.M. from the causes and on the date stated above.				
22. SIGNATURE <u>James R. Martin</u>		22b. DATE SIGNED <u>5-23-62</u>		
22c. PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>		22d. ADDRESS <u>65 SHAW ST. ANNAPOLIS, MD.</u>		
23a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-24-62</u>		
23c. NAME OF CEMETERY OR CREMATORY <u>ST. MARGARETS</u>		23d. LOCATION (City, town or county) (State) <u>ST. MARGARETS MD.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Ly</u>		25a. REC'D BY REGISTRAR <u>MAY 25 '62</u>		
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25c. ADDRESS <u>Annapolis, Md.</u>		



05405

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05401

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Linthicum c. LENGTH OF STAY IN 1b 7 y d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5 Eleanor Avenue				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Same b. COUNTY Same c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same d. STREET ADDRESS Same e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Raymond Yost				4. DATE OF DEATH May 20th 19 62			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/8/06	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Station Engineer				10b. KIND OF BUSINESS OR INDUSTRY Md. Match		11. BIRTHPLACE (State or foreign country) Pittsburg, Pa.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William Yost				14. MOTHER'S MAIDEN NAME Martha Carrick			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) from 1925 to 1939				16. SOCIAL SECURITY NO. 214-18-7429		17. INFORMANT Mrs. Anna Yost (wife) Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Has had coronary diseases since 1955. (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 5/20/62 Glen Burnie, Md.							
ACTUAL SIGNATURE Gustave H. Faubert, M.D.		EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 23, 1962		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or country) (State) Frederick Rd. Balto. Md.	
23. FUNERAL DIRECTOR George J. Gonce ADDRESS 4001 Ritchie Hwy. (25)				24a. REC'D BY REGISTRAR DATE MAY 25 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05406 CERTIFICATE OF DEATH 05402

1. PLACE OF DEATH a. COUNTY AA MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Orchard Bch.		c. LENGTH OF STAY IN 1b Orchard Beach	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1919 West End. Dr.		d. STREET ADDRESS 7919 West End Dr.	
3. NAME OF DECEASED (Type or print) Henry H. Zeller		4. DATE OF DEATH 5 31 19 62	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-2-1889
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist		10b. KIND OF BUSINESS OR INDUSTRY MD	
11. BIRTHPLACE (County & State, or foreign country) MD		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Zeller		14. MOTHER'S MAIDEN NAME Sophie Belto	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. Family	
17. INFORMATION Same		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiac Vascular Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 1961 to May 31, 1962 that (I) (we) last saw the deceased alive on May 29, 1962, and that death occurred at 3:30 PM, from the causes and on the date stated above.			
22a. SIGNATURE J. Brady Smith		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) J. BRADY SMITH		22d. ADDRESS Pawling Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) B	23b. DATE THEREOF 6-4-62	23c. NAME OF CEMETERY OR CREMATORY John W. Lee Cem	23d. LOCATION (City, town or county) (State) Allen B. Lee Md
24. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes		25a. REC'D BY REGISTRAR DATE JUN 4 '62	
ADDRESS 130 E. Fort Ave.		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

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